

October 2008



# Vermont Choice for Care Final Evaluation Plan

## Final Version

**Prepared by:**

Center for Health Policy and Research  
(CHPR), Long Term Care Unit

**Project Team:**

Darlene (Dee) O'Connor, PhD  
Emma Quach, MPA  
Jennifer Ingle, MS, CRC

**Project Consultants:**

Christine Clements, PhD, MPH  
Wen-Chieh Lin, PhD  
Judy Savageau, MPH

## Table of Contents

EXECUTIVE SUMMARY.....	3
SECTION I: INTRODUCTION.....	6
<i>Background</i> .....	6
<i>Intended Audiences</i> .....	7
<i>Logic Model—A Framework for the Evaluation Plan</i> .....	8
<i>Linkage between Evaluation Outcomes with Vermont Mission/Principles</i> .....	11
<i>Process and Outcome Components</i> .....	12
<i>Data Collection Strategies</i> .....	13
<i>General Considerations</i> .....	16
SECTION II: SHORT-TERM OUTCOMES.....	18
Outcome 1: Information Dissemination.....	19
Outcome 2: Access.....	23
Outcome 3: Effectiveness.....	27
Outcome 4: Experience with Care.....	33
Outcome 5: Quality of Life.....	35
Outcome 6: Impact of Waiting List.....	37
Outcome 7: Budget Neutrality.....	43
Section III: LONG-TERM OUTCOMES.....	45
Outcome 8: Public Awareness.....	45
Outcome 9: Health Outcomes.....	50
Section IV: GENERAL RECOMMENDATIONS.....	53
APPENDIX 1.....	55
Evaluation Plan List of Indicators.....	55
REFERENCES.....	68

## EXECUTIVE SUMMARY

In October 2005, to further increase access to home and community-based services while preventing unnecessary nursing facility care for elders and persons with physical disabilities, Vermont launched an 1115 waiver called Choices for Care (CFC). Choices for Care has several ground-breaking components. It encompasses the entire Medicaid nursing home budget as well as the existing Medicaid HCBS and enhanced residential care (ERC) waiver budgets for elders and adults with physical disabilities. Such consolidation enables a range of service and setting options (some options are new while other options were existing) for CFC participants. The main options are HCBS, ERC, consumer-directed and surrogate-directed personal care, a Cash and Counseling-based option called Flexible Choices, the option to pay spouses for care, Program for All-Inclusive Care for the Elderly (PACE), and a non-ERC 24-hour care option.

CFC devised formal mechanisms to allocate resources by making different settings/services available to participants, depending on whether they met the CFC highest, high, or moderate levels of need. Specifically, highest need participants (who meet nursing facility level of care) have access to all program options and settings. High needs participants (who also meet Vermont's nursing facility level of care but who have fewer needs than the highest need group) have access to all program options and settings, but only if funding were available. Moderate needs participants, who do not meet nursing facility level of care or Medicaid long-term care financial eligibility criteria, have access to a more limited scope of services--adult day services, homemaker services, and case management services. Through waiting lists for high and moderate needs participants, CFC can manage the budget and assure that those with the highest needs always have immediate access to the full range of long-term supports.

In June 2007, Vermont Department of Disabilities, Aging, and Independent Living (DAIL), the state unit responsible for the implementation and oversight of CFC, contracted with UMass Medical School's Center for Health Policy and Research (CHPR) to serve as its external evaluator and develop a full evaluation plan for CFC. The objectives of the evaluation plan were to articulate CFC's desired outcomes, specify high-level evaluation questions and methodology (including conceptual process and outcome indicators of success), and recommend ways for implementing the evaluation plan. The development of the evaluation plan occurred between June 2007 through June 2008, with input from Vermont state staff, providers, advocates, consumers, as well as national long-term care experts.

The evaluation plan is guided by nine desired outcomes that are postulated to be achievable given CFC processes within the specified timeframe, as depicted by the logic model.

Short-term Desired Outcomes (1-5 years):

1. **Information Dissemination:** Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.

2. **Access:** Participants have timely access to long-term supports in the setting of their choice.
3. **Effectiveness:** Participants receive effective HCBS to enable them to live longer in the community.
4. **Experience of Care:** Participants have positive experiences with the types, scope, and amount of CFC services.
5. **Quality of Life:** Participants report that their quality of life improves.
6. **Waiting List Impact:** CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing home, enhanced residential care, HCBS).
7. **Budget Neutrality:** Medicaid's cost of serving CFC participants is equal to or less than under the previous Medicaid and HCBS waiver funding.

#### Long-Term Desired Outcomes (over 5 years)

8. **Public Awareness:** Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long term care.
9. **Health Outcomes:** CFC participants' medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed.

In measuring the degree to which these desired outcomes are achieved, evaluation questions (at least one evaluation question for each desired outcome) are specified in a way to set forth an actionable and feasible evaluation undertaking within a relatively limited timeframe. For each evaluation question, both process and outcome indicators are identified, when possible, to serve as discrete markers for Vermont to immediately monitor to help discern whether or the degree to which desirable changes are occurring, e.g., increase in percentage of participants reporting that their quality of life is good or better. Where appropriate, the evaluation questions and indicators use existing data sources that Vermont has been collecting. CHPR sought to maximize the use of existing data sources but also has suggested other data sources or ways of using existing data sources, when appropriate.

The Vermont-generated data sources in the evaluation plan are:

- Annual Macro survey of direct feedback from CFC participants, other Vermont long-term care program users, and the general Vermont public living in the community regarding service quality, satisfaction, and quality of life
- CFC enrollment: Data on CFC enrollment by setting (HCBS, ERC, nursing facilities) and service type (consumer-directed, traditional agency), age, gender, level of need, as well as waiting list information
- Assessment: Community-dwelling participants are assessed using the Independent Living Assessment on an at least annual basis and nursing home admissions are assessed using the MDS. Both assessments contain information on functional and cognitive impairments.
- Medicaid Spending: Medicaid claims data contain individual-level Medicaid expenditures and utilization data while HCFA-64 Quarterly Reports, as

submitted to CMS, describe spending by aggregate spending by level of need and major service categories.

- Ombudsman Complaints Data: Descriptions of formally registered complaints, the setting of the service recipient, and the resolution of the complaints.
- Quality Management Unit's interviews of participants and provider on-site monitoring

Data sources in the evaluation plan also include:

- interviews with participants, family members, providers, and Vermont staff, and advocates (collected by CHPR and UVM under CHPR's contract with DAIL) and
- Medicare claims data (collected by CMS)

Overall, the evaluation plan is a comprehensive plan for conducting evaluation research to understand core aspects of CFC. Because some core aspects of CFC have not been fully implemented and current state funding may not be available to support all aspects of the evaluation plan, the evaluation plan could be implemented in a tiered manner by sequencing the evaluation work in the following manner:

- Prioritize evaluation questions or data collection where no baseline data exist and/or where there is immediate policy-making value
- Compile a profile of CFC participants, particularly through the linkage of multiple data sources
- Provide a snapshot of CFC achievement across desired outcomes at the mid-point of the demonstration period, prior to CMS review of the waiver approach
- Plan to repeat qualitative data collection, using the 2007-2008 qualitative data collection as a guide

As the evaluation plan was being finalized in August 2008, some recommendations in this evaluation plan were already being implemented. Most prominently, DAIL is inputting assessment data of 2008 community-dwelling participants into their electronic database that also stores enrollment and service plan data. Thus, the plan's evaluation questions, indicators, data sources, and analytic approaches will be updated on an annual basis to reflect the best available/known methods.

## SECTION I: INTRODUCTION

### *Background*

Vermont has been a leader in efforts to offer more community-based long-term care options for older persons and persons with disabilities. In 1996, Vermont Act 160 was passed to further reduce nursing facility utilization by diverting funding to community-based service options through a number of strategies. Notably, the Act prioritized waiver participants based on whether they wished to leave a nursing facility or were at risk for nursing facility admission. The Act also established and funded a network of long-term care coalitions around the state, with an aim to better coordinate services and assure access to long-term care. In addition, the Act created the Enhanced Residential Care (ERC) waiver program. Approved by the Centers for Medicare and Medicaid Services (CMS) in March 1996, the ERC waiver provided a residential alternative to nursing facilities by offering a 24-hour care option in licensed residential care homes for those who wished to live in the community but did not want to live alone. In addition, a home and community based services (HCBS) waiver had already been providing services in the community to adults with physical disabilities and elders, such as case management, personal care, and adult day care.

In October 2005, Vermont made major transformations to its long-term care system and launched its Choices for Care (CFC) waiver. CFC's primary goal is to further increase access to HCBS while preventing unnecessary nursing facility care for elders and persons with physical disabilities. CFC, an 1115 waiver, consolidated some existing services (the ERC waiver, HCBS waiver specifically for elders and adults with physical disabilities, consumer-directed and surrogate-directed care, and nursing home services). CFC also created new long-term care options, such as the Cash and Counseling-based option called Flexible Choices, the option to pay spouses for care, PACE, and a non-ERC 24-hour care option. Thus, CFC came to encompass the Medicaid nursing home budget, in addition to the previous Medicaid HCBS and ERC budgets for elders and adults with physical disabilities. Additionally, CFC devised formal mechanisms to allocate resources by making different settings available to participants, depending on whether they met the CFC highest, high, or moderate levels of need. Specifically, highest need participants have access to all program options and settings. If funding is available, high need participants have access to all program options and settings. Moderate needs participants have access to a more limited scope of services--adult day services, homemaker services, and case management services.

In June 2007, Vermont Department of Disabilities, Aging and Independent Living (DAIL), the state unit responsible for the implementation and oversight of the CFC waiver, contracted with UMass Medical School's Center for Health Policy and Research (CHPR) to serve as its external evaluator to develop a full evaluation plan for CFC. Prior to the initiation of the development of the evaluation plan, CHPR and DAIL staff held a kick-off meeting on June 22, 2007 at which DAIL provided an overview of current operations and program issues and DAIL objectives with regards to the evaluation. The

work on the evaluation plan began immediately after that. Specifically, the objectives of the evaluation plan are to:

- Articulate the program's desired outcomes and the major processes that lead to those outcomes
- For each desired outcome, specify overarching evaluation questions, key process and outcome indicators, data sources, and analytic approach.
- Identify and maximize how CFC current data collection efforts, quality improvement processes, and any future monitoring processes fit into the overall evaluation schema
- Delineate general considerations for DAIL in deciding how to implement the evaluation plan, including roles for DAIL and CHPR
- Make overarching recommendations on implementation of evaluation and outcome-specific recommendations.

### *Intended Audiences*

The audiences for this evaluation plan include entities both within and outside of Vermont. The direct audience of the evaluation plan is the Vermont DAIL. The evaluation plan can serve as a roadmap for multiple units across DAIL that are involved in the design (and re-design) as well as initial and continuous implementation of CFC. The evaluation plan is also intended for discussion with Vermont stakeholders, including consumers, family members, advocates, and members of the provider community. Such transparency supports a participatory approach to evaluation research and will enable these stakeholders to contribute to the evaluation at various steps including providing comments on the plan and providing feedback through interviews and surveys. CMS is also another direct audience; this evaluation plan meets the CMS requirement for an external evaluation of the 1115 waiver. Finally, the evaluation plan (and evaluation results) may also be of interest to other states undertaking or contemplating similar modifications to their Medicaid long-term care programs.

Given the audiences, CHPR and DAIL have sought diverse input in the development of this evaluation plan. Specifically, an evaluation roundtable meeting was held in January 2008. This was a two-day meeting to elicit feedback on the core components of the evaluation plan from DAIL staff, national long-term care experts, and key consumer representatives. A discussion of each component allowed for a full critique of the evaluation plan. A summary of the roundtable meeting is available for review.<sup>1</sup> This meeting confirmed the general direction and helped improve the plan through the attendees' suggestions for refinements, additional data sources, and methodological approaches. Subsequent to the roundtable, discussions with providers and the DAIL Advisory Board gathered further feedback to help refine the plan presented in this document.

---

<sup>1</sup> Contact Emma Quach for a copy of the evaluation roundtable summary.

### *Logic Model—A Framework for the Evaluation Plan*

CHPR's first step in developing the evaluation plan was to develop a CFC logic model depicting primary CFC processes and desired outcomes. A logic model is a beneficial evaluation and program management tool that captures the relationships among the program's resources, activities, and desired outcomes.<sup>2</sup> It systematically and visually depicts the relationship (as depicted by the arrows) between program inputs, activities, outputs, and the desired short- and long-term outcomes for the program. "Inputs" denote the entities performing "activities" that are key to the implementation of the Choices for Care waiver. "Outputs" denote actual services delivered and activities made possible by the "inputs", e.g., people are receiving services, program oversight is occurring. "Outcomes" are differentiated by whether these are expected to be observed within the demonstration period (short-term outcomes) or beyond (long-term outcomes).

The logic model serves several purposes. First, by elucidating the mechanics of the program, it serves as a starting point for the evaluation. In other words, program staff and evaluators affirm the goals and objectives of the program and agree on how the program works, and its desired outcomes, before evaluation activities are initiated. Second, the logic model can be a reference tool for program staff to use in continuous quality improvement efforts. For instance, CFC staff can anticipate how specific outcomes or processes may be affected when other components of the program system are added or otherwise modified.

In fall 2007, CHPR provided a preliminary logic model to DAIL. This has been refined through subsequent meetings and discussions with DAIL, Vermont stakeholders, and outside long-term care experts. The current logic model for the CFC evaluation appears on the next page and the short-term and long-term desired outcomes for CFC are described below.

#### Short-term Outcomes (1-5 years):

1. **Information Dissemination:** Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.
2. **Access:** Participants have timely access to long-term care supports in the setting of their choice.
3. **Effectiveness:** Participants receive effective HCBS to enable participants to live longer in the community.
4. **Experience of Care:** Participants have positive experiences with the type, scope, and amount of CFC services.
5. **Quality of Life:** Participants' reported that their quality of life improves.
6. **Waiting List Impact:** CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing home, enhanced residential care, HCBS).

<sup>2</sup> W.K. Kellogg Foundation Logic Model Development Guide:  
<http://www.wkcf.org/Pubs/Tools/Evaluation/Pub3669.pdf>

7. **Budget Neutrality:** Medicaid's cost of serving CFC participants is equal to or less than under the previous Medicaid and HCBS waiver funding.

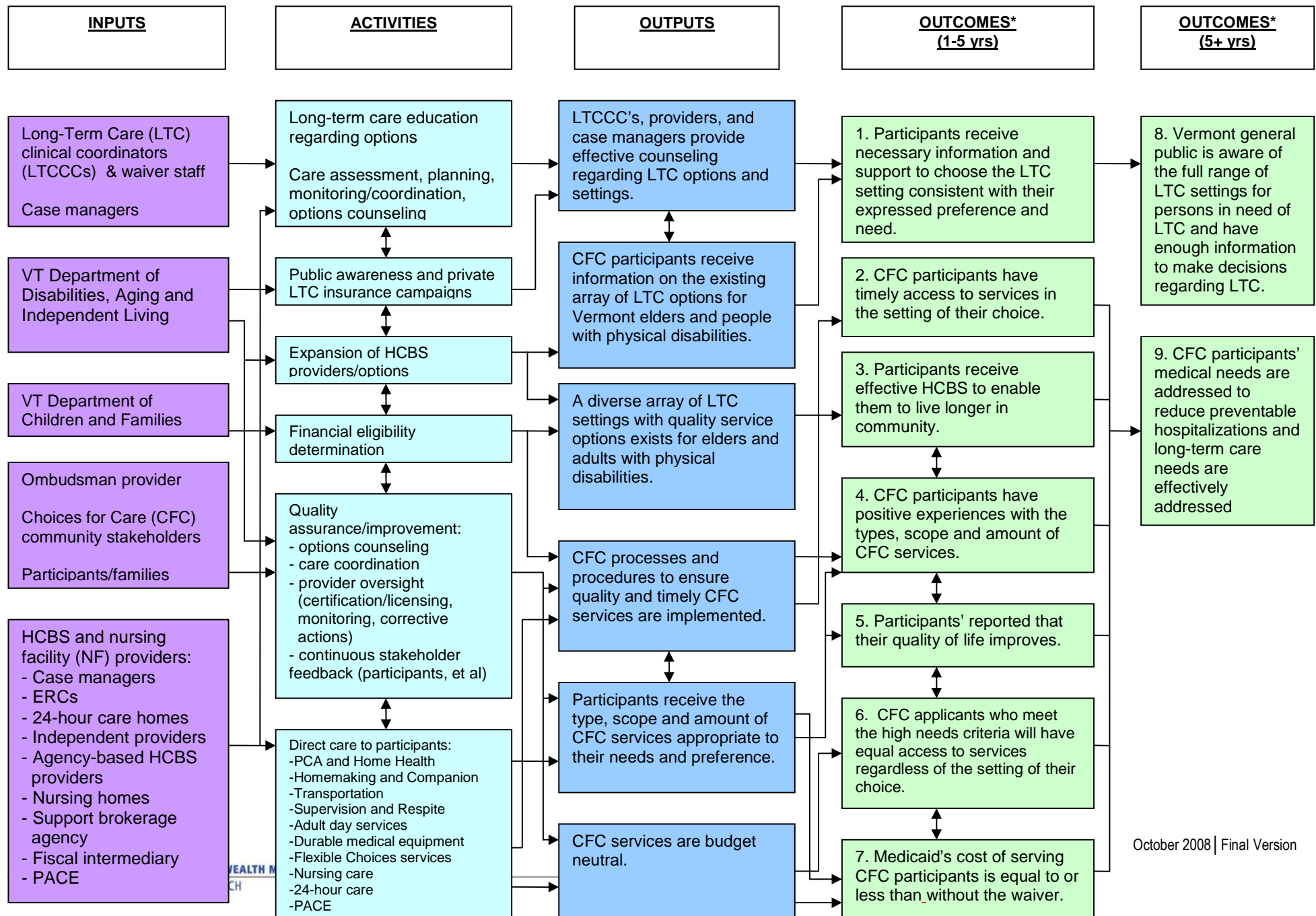
Long-Term (over 5 years)

8. **Public Awareness:** Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long term care.
9. **Health Outcomes:** CFC participants' medical needs are addressed to reduce preventable hospitalization and their long-term care needs are effectively addressed.

Subsequent to the logic model development, an evaluation plan was developed. The CFC evaluation plan used the desired outcomes in the logic model as starting points. We first reviewed relevant articles in the scientific literature related to the desired outcomes or areas of state and federal evaluation interest, as articulated by CFC waiver documents. We also reviewed how these outcomes have been measured with respect to elders and adults with physical disabilities with functional impairments. We used this information (state and federal policy interests, and Vermont's Choices for Care goals) to inform our development of specific evaluation questions. In developing each evaluation question, we also kept in mind the feasibility of answering each evaluation question with readily available data sources, e.g., existing data gathered by Vermont, CMS, and other researchers. We developed process and outcome indicators grounded in CFC inputs, activities, and outputs as well as current knowledge about on how such outcomes are measured.

The core components of the evaluation plan are anticipated program outcomes and associated evaluation questions and their corresponding key indicators, data sources, analytic approach, and limitations. Evaluation questions correspond to desired outcomes, as indicators, data sources, analytic approach, and limitations correspond to each evaluation question.

Different fonts and sizes in this table



### *Linkage between Evaluation Outcomes with Vermont Mission/Principles*

DAIL's mission, as articulated in the 2005 Annual Report is "to make Vermont the best state in which to grow old or to live with a disability—with dignity, respect and independence." DAIL has identified nine core principles that support this mission:

1. **Person-centered**—the individual will be at the core of all plans and services
2. **Respect**—individuals, families, providers, and staff are treated with respect
3. **Independence**—the individual's personal and economic independence will be promoted
4. **Choices**—individuals will direct their own lives
5. **Living well**—the individual's services and supports will promote health and well-being
6. **Contributing to the community**—individuals are able to work, volunteer, and participate in local communities
7. **Flexibility**—individual needs will guide our actions
8. **Effective and efficient**—individual's needs will be met in a timely and cost-effective way
9. **Collaboration**--individuals will benefit from our partnerships with families, communities, providers and other federal, state and local organizations

These core principles are the foundation for Choices for Care and other DAIL initiatives, and they relate directly to the desired outcomes for services. The current CFC evaluation plan reflects these principles but is organized in a way that links the specific outcomes to the program inputs and activities as outlined in the logic model. Table 1 provides a crosswalk between the short-term desired outcomes and the core principles stated in the DAIL's Quality Management Plan *and* a crosswalk between the specific evaluation questions and indicator types pertaining to the desired outcomes and core principles.

Table 1 - Crosswalk between Evaluation Outcomes and Vermont's Principles<sup>3</sup>

Vermont Values	Desired Outcomes						
	1 Information (also long-term outcome # 8)	2 Access	3 Effectiveness (also long-term health outcome # 9)	4 Experience of Care	5 Quality of Life	6 Waiting List Impact	7 Budget Neutral
Person-Centered	1.1A	2.1A 2.2B	3.2A	4.1A		6.1A 6.1B	
Respect				4.1A 4.1B			
Independence			3.1B 3.3B		5.1B		
Choices	1.1A 1.1B 8.1B 8.2A 8.2B		3.2A		5.1B	6.1A 6.2B	
Living Well			9.1B		5.1B	6.1A 6.2B	
Contributing to the Community					5.1B		
Flexibility	1.1B	2.1A 2.2A	3.1A			6.1A	
Effective and Efficient		2.1B 2.2A 2.2B	3.1B 3.2 3.3B 9.1B	4.1B	5.1B	6.1B 6.2A 6.2B	7.1A 7.1B
Collaboration	8.2A		3.2A 9.1A			6.1A	

### *Process and Outcome Components*

CHPR's evaluation plan has two major components: the evaluation of process and the evaluation of outcomes. The process evaluation focuses on the inputs, activities, and outputs necessary to the implementation and operation of the initiative. Particularly important will be gaining the perspective of state agency staff regarding the general successes and challenges of implementing CFC, as well as gathering ideas on potential strategies to address any barriers. Such information helps policy makers and program staff to learn what works and what

<sup>3</sup> Note: The numerals in the cells denote the evaluation questions that are discussed in Sections III and IV of this document while letters following each numeral in the cells denote the type of indicators ("A" for process indicators and "B" for outcome indicators).

does not and to make adaptations along the way. The process evaluation will also help other organizations or policy makers not directly involved in CFC to understand what is involved in implementing such an initiative, what pitfalls to avoid, and what program components or activities are essential to the initiative's success.

Although any program modifications made during implementation and operation of the initiative may increase the difficulty of attributing a particular input, activity or output to a particular outcome, we recognize that adaptations over time may help CFC achieve its desired outcomes. We thus acknowledge that the emphasis of the evaluation is less on attributing certain effects to CFC per se but more on documenting changes to waiver operations and its participants over the demonstration period. Therefore, adaptations and adjustments to the waiver during the course of the demonstration period are expected.

Like the process evaluation, the outcome evaluation flows from CFC inputs, activities, and outputs. Although the evaluation plan encompasses both the short-term (1-5 years) and long-term (over 5 years) outcomes, the immediate focus of the evaluation is on the short-term outcomes. However, evaluating CFC on long-term outcomes (more difficult undertaking) can illuminate on the reach of CFC impacts while contributing to general knowledge of long-term care services.

The evaluation questions associated with each outcome have both process and outcome indicators that may involve different data collection tools and methods. Therefore, as we discuss each question, we first describe the process indicators and then the outcome indicators. Some indicators are described on a conceptual level and will need to be further specified in the future.

### *Data Collection Strategies*

We weighed the utility of gathering quantitative data that enumerate dimensions of CFC with gathering qualitative data that can provide more depth of understanding. We determined that a mixed method approach would be valuable to providing breadth and depth. We also sought to minimize the addition of new or potentially cumbersome data collection methods, but proposed new data collection methods where we felt their potential benefits may justify their potential costs. However, an overarching consideration for the data sources proposed in the evaluation is that the analyses of a single data source may be limited to descriptive analyses, unless a data source is linked to other CFC participant characteristics to evaluate associations among subgroups or unless an appropriate comparison group to CFC participants is identified.

### *CFC Data Sources*

The key data sources for the evaluation that we reference in Section II (short-term outcomes) and Section III (long-term outcomes) provide both qualitative and

quantitative information. Although each data collection mechanism cited has its strengths and weaknesses, each indicator is crucial to addressing some aspect of the evaluation plan or some segment of the CFC population. Where appropriate, we recommend in Sections II and III ways to enhance how data are collected or analyzed. The data sources are as follows:

*Macro survey:*

The Macro survey collects primarily quantitative data. It is commissioned by DAIL to gather feedback on quality of life from both general Vermonters and users of DAIL long-term care programs and service quality and satisfaction from the latter group. (The quality of life questions are administered to a representative sample of the general Vermont public). The survey is administered with a probability sample of community-dwelling participants in CFC (including Adult Day and Homemaker Services participants), Attendant Services Program, and Home-Delivered Meals. The survey was conducted in 2002, 2006, and in 2007. The 2007 survey also contained questions on knowledge of long-term care options and general assessment of overall health and health transition from Short-Form 36. SF-36 is a thirty-six item self-administered survey of physical and mental health that has been tested for validity and reliability (Ware, 2008). The question on overall health has also been incorporated into other surveys.

*Interviews and focus groups conducted by the CHPR and University of Vermont (CHPR/UVM):*

This qualitative data gathering from key stakeholders began in the fall of 2007/ winter 2008 and is planned to continue throughout the demonstration period of CFC (short-term timeframe of the evaluation). To date, semi-structured interviews have been conducted with consumers, advocates, and state staff, and focus groups with providers and family members. The first round of interviews and focus groups explored knowledge of CFC options, financial and clinical eligibility process, service access and quality, participant choice and preference, and HCBS ombudsman service. While the first round of interviews and focus groups were conducted on a wide range of topics to gather perspectives about a variety of aspects of CFC, future ones could focus on areas targeted for improvement to provide more in-depth information.

*Assessment Data:*

DAIL collects assessment data on Choices for Care enrollees to support program implementation. These data are also highly relevant for the evaluation. For example, highest and high level of needs HCBS participants are assessed and re-assessed using the Independent Living Assessment (ILA), while the moderate needs group participants are usually assessed with a shorter version of the ILA. ERC residents are currently assessed using a resident assessment tool known as the “gold form”, although plans are underway to replace this with a new assessment tool. The ILA and the “gold form” share some data elements including ADL self-performance and behavioral symptoms, and these data were

also collected on HCBS waiver participants prior to CFC. Although the variety of individuals collecting assessment data may lead to problems in inter-rater reliability, the regular collection of these data on the CFC population make the assessment data critical for understanding how CFC has evolved.

Clinical assessment data from the ILA and “gold form” are available mostly in paper format. However, the shortened ILAs for some moderate needs group participants are stored electronically in DAIL’s database, Social Assistance Management System (SAMS/OMNIA). For several years, DAIL has been hoping to make ILA data for other CFC participants available electronically. In June 2008, DAIL funded an effort to input electronically the most recent ILA (a subset of ILA variables) for current HCBS participants into OMNIA.

#### Enrollment Data

CFC participant demographic, enrollment, and service authorization data are stored electronically in SAMS. Data elements include: participant age and gender, enrollment group by level of need with start and end dates, and authorized service plans with service types, amounts, and providers, including start and end dates.

#### Surveys conducted by the Vermont Quality Measurement Unit (QMU):

The QMU within DAIL administers a survey, expanded from the CMS Personal Experience Survey, to a 10% convenience sample of CFC participants within each provider under the oversight of the QMU (area agencies on aging, home health agencies, and adult day providers). The survey is administered in-person with participants as part of the on-site provider monitoring QMU conducts every other year. Survey results are available in “OMNIA” within SAMS.

#### Record reviews by the QMU:

As part of the on-site monitoring of providers, QMU reviews written case records of CFC participants held at provider agencies. Records include assessments, care plans, case management plans, and all other records pertaining to the participant related to the service the agency provides. Record reviews help to identify corrective actions and appropriate follow-up actions by the agency.

#### Ombudsman Complaints Data

The CFC ombudsman contractor collects data related to complaints from CFC participants. The data include the number of complaints filed and the setting (HCBS, residential care homes, and nursing homes). The data also include whether complaints were resolved fully or partially, or withdrawn, etc.

#### Medicaid Paid Claims:

Vermont Medicaid claims contain Medicaid expenditures for all service types and amounts for CFC participants as well as all Medicaid beneficiaries.

*Minimum Data Set (MDS):*

Consistent with federal standards, Medicaid nursing home residents are assessed and re-assessed using the MDS. As part of their licensing of nursing homes, DAIL's Division of Licensing and Protection reviews a sample of completed MDS assessments of CFC participants, among other activities. Use of the MDS is subject to a data use agreement between CMS and the State of Vermont.

*HCFA-64 Reports*

These are quarterly reports submitted by state Medicaid agencies to the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration or HCFA). The reports document unadjusted Medicaid payments by service category along with recoupments and third-party liability collections. The reports also document expenditures for previous years.

*General Considerations*

The evaluation plan is based on a comprehensive set of desired outcomes and involves multiple data collection sources. The evaluation plan also lays out activities to be conducted over multiple years in a phased approach. Measuring whether the desired CFC outcomes have been achieved will involve ongoing—and in some cases--additional data analysis. Inevitably, DAIL will need to decide on how to proceed with implementation of the evaluation plan. Such decision-making will need to confront tradeoffs, and specific decisions will be made based on available funding and through contract negotiations. While this evaluation plan aims to maximize methodological rigor, several approaches could be considered in implementing the evaluation plan:

- Prioritize the electronic entry of assessment data from the ILA which can be used for multiple evaluation questions and which will also be of use for program operations and future rate-setting. In doing so, DAIL would need to consider a host of factors, including whether to include past ILAs or past participants, if change over the course of CFC can be evaluated. As noted, this has been under discussion at DAIL for several years and is currently underway as of August 2008.
- First address evaluation questions or indicators that have more immediacy in terms of the data value for policymaking. There may be a need to gather the information or focus on specific indicators to inform particular policy questions at hand. In addition, specific evaluation questions may be of priority because they fill in gaps where little data exist thus far. For these reasons, CHPR collected baseline information through focus groups and interviews while concurrently developing the longer-range evaluation plan.
- In year 2, focus on developing as complete a profile of CFC participants as possible and determine the extent to which participant experience with

care/quality of life are linked to their demographic characteristics, program category, level of need, or other factors.

- The participant profile can lay the foundation for an interim report that addresses:
  1. To what degree DAIL undertook the activities described in the approved waiver application
  2. What were the experiences of CFC participants, and
  3. What was the CFC impact on long-term care expenditures

Such data will inform CMS as the renewal request is reviewed

- In year 3, follow-up on qualitative data collection methods, such as interviews or focus groups with participants and other stakeholders to follow-up on the evaluation baseline information and to probe further on specific evaluation questions. This approach is particularly important for evaluation questions or indicators where information is counter-intuitive or where summative data raise more questions than they answer. Qualitative data can also inform the development of more precise measurement instruments or follow-up questions that can be administered to more individuals through future surveys.
- Since it is anticipated that the 1115 CFC waiver will be renewed at the end of the five-year implementation period, DAIL should plan follow-up evaluation activities in subsequent years. The evaluation plan provides a roadmap for these future activities as well.
- Since some of the proposed evaluation activities may be beyond the available resources at DAIL, CHPR and DAIL should work together to identify potential external opportunities to fund components of the evaluation plan.

## SECTION II: SHORT-TERM OUTCOMES

As indicated in the logic model, short-term outcomes are those that are anticipated during the first five years of CFC.<sup>4</sup> The short-term outcomes that are discussed in this section are:

1. Information Dissemination
2. Access
3. Effectiveness
4. Experience of Care
5. Quality of Life
6. Waiting List Impact
7. Budget Neutrality

In this section, we first present the intended program outcome with a brief summary of its significance, followed by the associated evaluation question or questions. For each question, we present the process and outcome indicators and associated data sources, followed by the analytic approach and any outcome-specific recommendations and limitations<sup>5</sup>.

---

<sup>4</sup> This period includes the approximately two years prior to DAIL's evaluation contract with CHPR that began in July 2007.

<sup>5</sup> These indicators will guide the annual evaluation reporting on CFC. Additionally, with data provided by DAIL, each annual evaluation report will begin with a profile of CFC current enrollees by gender, age, region, and CFC level of need. If assessment data are entered and made available in SAMS, the profile will also include the population distribution by functional and cognitive status. This information will provide context for understanding the short-term outcomes and will help document the effect of program changes over time.

## Outcome 1: Information Dissemination

***CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.***

### Significance

At the federal and state level, government has placed increasing value on ensuring that program participants have meaningful choices for long-term care, that they are entitled to receive long-term care in settings other than nursing homes, and that they receive support to make decisions among these choices. In keeping with these values, CFC has expanded the range of long-term care services and settings that are available for its participants and aims to involve the participant to the greatest extent possible in their long-term care planning. To educate participants about their long-term care service and setting options, clinical coordinators (LTCCCs) throughout the state provide options education to every CFC participant at the point of program enrollment. A participant's case manager, who follows the participant over time, provides more in-depth and ongoing options counseling as necessary.

Several factors, however, affect both the extent to which participants are aware of long-term care options and are supported to make informed decisions regarding their long-term care. For example:

- Participants may not receive adequate information about the range of choices, and even when they do, they may not fully understand their options and the options' benefits and drawbacks or may be overwhelmed by the information.
- When decisions about long-term care are made quickly, for example because of a medical crisis for the participant or death/illness of a caregiver, there may not be time for adequate education about options to occur. Additionally, counseling for a participant who has been hospitalized may occur after discharge to a nursing home rather than before.
- Care professionals (providers) often do not directly ask participants their preferences for services and may assume that individuals with cognitive and functional impairments lack the capacity to make choices over their care.
- Efforts to educate hospital discharge planners, primary care clinicians, and others about long-term care service and setting options may be constrained by the LTCCCs' workload.
- The stress on family caregivers and other family members may lead to their preferences taking precedence over participants' preferences. Likewise, family members may not understand the elderly participant's values and preferences. During a crisis, preferences of the participant may be poorly understood or overlooked.

October 2008 | Final Version

- Family member, provider, and participant attitudes regarding specific long-term care settings can impact whether participants make supported and informed decisions regarding their long-term care.

These factors warrant monitoring to support CFC in meeting the desired information dissemination outcome and to determine whether CFC should craft targeted efforts to improve knowledge and decision-making support. To explore this area, CFC will need to understand whether participants receive adequate information on long-term care setting options and whether service planning and delivery are responsive to participants' expressed preferences.

### **Question 1.1: To what extent did participants receive information to make choices and express preferences regarding services and setting?**

#### **Key Indicators**

##### **A. Process Indicators:**

Process indicators, with their corresponding data sources, include:

1. The way in which decisions were made about the kinds of services a participant would receive (CHPR/UVM interviews)
2. Percentage of CFC participants rating "average" or above to the survey question that "*people listen to [their] needs and preferences*" (Macro survey)
3. Percentage of CFC participants responding affirmatively to "*Whether paid workers give participants enough information so participants can make decisions*" (QMU interviews)
4. Percentage of CFC participants responding affirmatively to "*When developing your service plan, did someone talk about your services AND other services that might be available?*" (QMU interviews)

In addition, participants' knowledge of long-term care options at the time of hospital discharge is considered an important area to explore because access to information at that time of transition could impact the setting to which the participant is discharged. The Macro survey will collect this information on Vermont citizens as well as CFC participants who were hospitalized within six months prior to responding to the Macro survey.. This will provide data about the broader availability of long-term care information to Vermont citizens, regardless of whether they were CFC participants<sup>6</sup>. At CHPR's request, the following indicators were added to the Macro survey for 2007 and subsequent years:

---

<sup>6</sup> This information could also provide data relevant to the long-term outcome of public awareness.

5. Percentage of participants reporting affirmatively to survey question *“Before you left the hospital [if hospitalized], did someone talk to you about ways of getting the help you needed with daily activities?”* (Macro survey)
6. Percentage of CFC participants reporting affirmatively that their *“hospital dischargers took their preferences into account when planning their discharge”* (Macro survey)
7. Percentage of participants reporting affirmatively to survey question *“Were you involved in making decisions regarding the help you needed with daily activities?”* (Macro survey)

Other potential process indicators are:

8. DAIL efforts to further strengthen the options education, both at initial enrollment and ongoing, that is delivered by LTCCC’s and case managers (CHPR/UVM interviews)
9. Change in participants and providers’ attitudes towards long-term care options and settings between 2007 and 2009 (CHPR/UVM interviews)

#### B. Outcome Indicators:

Several questions in the Macro survey and QMU interviews collect valuable information relevant to indicators of the extent to which participants receive information on long-term care options. These include questions that capture individuals’ involvement in care planning, which reflect their access to information that enabled them to make choices and participate in the decisions affecting their care, as well as options education and provider attitudes.

The following are the outcome indicators:

1. Increase in percentage of CFC participants who rate “good” or above to survey question that they *“had choice and control when planning for their services”* (Macro survey)
2. Increase in percentage of CFC participants who rate “good” or above on survey question of whether *“service fits within their schedule”* (Macro survey)
3. Increase in percentage of participants responding affirmatively to *“Do you have a say in how your services are provided?”* (QMU interviews)
4. Increase in percentage of participants responding affirmatively to whether their *“current setting is setting of choice”* (QMU and CHPR/UVM interviews)
5. Increase in percentage of participants responding affirmatively to whether they *“make the decisions that affect their lives”* (QMU interviews)

## **Analytic Approach**

Qualitative data from CHPR/UVM interviews will be thematically analyzed to facilitate an understanding of the mechanisms by which long-term care information is transmitted to CFC participants and how choice is promoted or hindered. Quantitative data from the Macro survey and QMU interviews will be presented descriptively to show the number and percentage of responses to each quantifiable indicator, and for Macro Survey, analyzed to assess changes over time and differences by participant characteristics, e.g., age, gender, region, needs/enrollment group (highest, high, moderate), CFC program service types (consumer-directed services, Flexible Choices), and other.

A benefit of linking Macro survey data to participant characteristics is the ability to evaluate whether participant knowledge and perceived support in decision making vary by age, sex, or CFC needs group. If the full ILA data are entered in the SAMS system, linkages between data sets would add potential for understanding participant knowledge in relation to physical and cognitive functioning, and other participant characteristics. This would be particularly valuable because the moderate needs group does not receive options education from long-term care clinical coordinators, whereas the highest and high needs group do.

## Outcome 2: Access

***Participants have timely access to long-term care supports in the setting of their choice.***

### Significance

The actual use of CFC services and its impact on participant health status and quality of life is clearly subject to participants' access to these services. Despite their insurance coverage, dually eligible elders and persons with disabilities still face barriers to accessing care. These barriers can be broadly grouped as organizational, financial and geographic (Niefield and Kasper, 2005), and access constitutes an important measure of quality according to CMS.

### *Timeliness*

One aspect of access important for the CFC target population is timeliness of services. Timeliness of HCBS may be particularly important for individuals being discharged from hospitals in an effort to avoid unnecessary nursing home placement or for diversion or transition to occur.

Multiple factors affect the timeliness of HCBS. Because applicants to the highest and high levels of need group must first undergo clinical eligibility and financial eligibility determination, either process could affect the timeline before actual services begin. Once determined eligible clinically and financially for CFC, a participant may still experience a time lag in service due to delays in service authorization. For instance, there may be a lack of agreement between LTCCCs, case managers, and participants regarding services to be included on service plans. Finally, availability of HCBS providers (e.g., personal care attendants, licensed nurse aides, and/or enhanced residential care providers) can also affect timeliness of services. Provider capacity is particularly subject to geographic locations and can affect whether some segments of CFC population, e.g., persons transitioning from nursing homes or persons with dementia or mental illness, can secure qualified and reliable providers. Such factors can affect the timeline before service initiation for new participants and current participants who may experience a change in assessed needs.

Nevertheless, measuring timeliness of CFC services is complicated by several factors. First, measuring timeliness of eligibility determination involves DAIL and the Department for Children and Families (DCF). DAIL is the entity conducting clinical eligibility and the DCF is the entity conducting financial eligibility, thus requiring that these two processes be evaluated separately. Second, there is currently no systematic mechanism that can quickly retrieve information on the time elapsed between starting points of reviews and completion of reviews, (Currently, starting points of clinical and financial review and application receipt

dates are available). Third, new applicants to CFC who are not already eligible for Medicaid may be particularly subject to timeliness issues. Nevertheless, DAIL and the DCF are well aware of the existence of a problem with timeliness and lack of information on timeliness of these processes. Likewise, the Vermont Aging and Disability Resource Center grant aims to measure the duration of clinical and financial eligibility determination process. In terms of service authorization and initiation, a complicating factor is that HCBS authorization dates are stored in SAMS while discrete service initiation data (i.e., the first day of actual service data are stored on an individual provider basis).

We thus leverage the analysis of existing data collected on timeliness of services to provide data to help DAIL evaluate past performance and inform any future initiatives to further improve timeliness

### *Service Delivery*

In addition to timeliness of HCBS, another issue related to access is whether CFC providers can deliver services as approved in participants' service plans, a measure of provider capacity, a measure of the accuracy of the assessment and service plan. Measuring this provides information on the scope and amount of actual service delivery compared to the scope and amount of services participants need, as reflected in the service plan. It will be important to account for periods when participants do not need such services, e.g., when they are in hospitals.

Because actual service delivery is based on a needs assessment and service planning, it is important that both assessments and service plans actually reflect current needs--a condition that may not be consistently met. Recognizing that participants, case managers, and LTCCC's may perceive participant needs differently, evaluation of this aspect of desired outcome on access uses the assessment as a starting point, while desired outcome #1 (participant preferences) focuses on participant and family members' perceptions of their own needs and services. Another assumption behind an evaluation of service delivery is that assessments accurately reflect needs and the presence of other services (e.g., Medicare home health services). While this assumption may be subject to debate (and such an issue would not be unique to CFC), assessments remain a source of statewide data for monitoring effectiveness of service delivery.

### **Question 2.1: Are new CFC participants or NH residents who seek discharge able to receive CFC services in a timely manner?**

#### **Key Indicators**

##### **A. Process Indicators:**

1. DAIL or DCF initiatives or efforts to improve the timeliness or general user-friendliness of the financial eligibility process (Interviews with DAIL or DCF staff and review of DAIL and DCF documentation related to these initiatives)

**B. Outcome Indicators:**

1. Percentage of CFC participants rating “average” or above on survey question “*services were timely*” (Macro survey)
2. Decrease in number of stakeholders reporting specific barriers to timely services (CHPR/UVM interviews)

**Analytic Approach**

We propose, that as part of the evaluation of this question, documenting any initiatives or efforts by DAIL or DCF to streamline or improve the financial eligibility determination process, e.g., making the process more user-friendly or timely. Such information helps complete a timeline of CFC activities that could have an impact on desired outcomes.

In addition, interviews with stakeholders and participants and their family members at least every other year regarding timeliness could be analyzed to discern any differences in themes over time. In addition, this source of data will be invaluable in identifying ways to improve timeliness. This, in turn, may create new processes to be monitored.

Lastly, survey results can be analyzed by different levels of need or by region to provide quick information on how CFC is progressing on this front.

**Question 2.2: To what extent are CFC participants receiving the types and amounts of supports consistent with their currently assessed needs?**

**Key Indicators**

**A. Process Indicators:**

1. Ways in which the assessment, service planning, and delivery processes facilitate or pose barriers to service access as reported by stakeholders (CHPR/UVM interviews)
2. Average cost of approved plans of care compared to average actual cost per person (SAMS/EDS)

**B. Outcome Indicators:**

1. Number and percentage of complaints from CFC participants regarding CFC service scope or amount (Complaints data from ombudsman)
2. Percentage of CFC participants who rate “almost always” or better to the question “*the services meet your needs*” (Macro survey)

## **Analytic Approach**

Participant data from the Macro survey will be analyzed by various subgroups (e.g., gender, age, level of need, region of state) and by change from the previous year. Qualitative data can be analyzed to identify any patterns or trends in responses and any ways that CFC processes may be improved.

Average approved care plan cost *per person* and average actual service costs per person can be analyzed by subgroup as well. Because there are multiple possible reasons for the discrepancy between approved and actual costs (i.e., some are related to CFC service access while others are not), these data will help further understand CFC service access and provide the basis for further investigations. For instance, if warranted by the data, a sample of cases could be studied in-depth to understand how the assessments, care plans, and service delivery unfolded.

While complaints data is subject to underreporting, it is one of multiple data sources that partially inform this evaluation question. As more people know and use ombudsman service, the number of complaints may consequently rise. Therefore, both the actual number of complaints and patterns of complaints will be analyzed.

## **Recommendations**

Depending on any future initiatives DAIL or DCF undertake regarding timeliness of clinical or financial eligibility determination, CHPR can further develop additional indicators on timeliness. For example, time from application submission to completion of clinical determination or time from clinical determination to financial determination could be informative to understanding timeliness. The development of such indicators, however, would first require changes in both DAIL and DCF data collection efforts.

### Outcome 3: Effectiveness

***Participants receive effective HCBS to enable them to live longer in the community.***

#### Significance

CFC aims to provide effective HCBS to increase the likelihood that individuals will be able to remain longer in the community and hence reduce nursing facility care. Thus, it is important to measure the effectiveness of HCBS in achieving this overarching intent. Several broad measures of effectiveness are particularly salient to evaluating CFC services:

- the ability of all participants to have their needs met while they are living in the community,
- the degree to which services are well-coordinated; and
- the extent to which individuals who could be served in the community are diverted or transitioned from nursing facilities

#### *Getting needs met while living in the Community*

Given the general goal of CFC to support participants in community settings, monitoring the proportion of CFC participants living in the community is crucial. Furthermore, it is also important that CFC participants' daily living needs are met. Although it is recognized that participants may choose to stay in their own homes with unmet needs, rather than moving into a more communal setting where all their ADL needs are met, understanding the degree to which CFC participants continue to have unmet ADL needs is likely to impact their satisfaction and quality of life, as well as their future risk of nursing facility care. The Macro survey includes a question about the extent to which CFC services meet the individual's needs as well as question that address specific aspects of community living that are not necessarily tied to specific services (e.g. getting where I need to go getting around inside the house, amount of contact with family and friends)

In addition to understanding the general effectiveness of HCBS, we also recognize that CFC is unique in its creation of the moderate needs group as a way to provide services earlier than federal rules allow under traditional HCBS waivers since the individuals are not eligible for nursing home admission. The moderate needs group is, in fact, quite different from the highest/high needs groups because they do not have an option to receive services in a nursing home, have access to only case management, adult day, and homemaker services (without access to consumer or surrogate-directed or Flexible Choices). Furthermore, the moderate needs group is heterogeneous in that its membership is a function of multiple factors - available moderate needs funding, the existence of a waiting list for high needs participants, and meeting the clinical and financial eligibility criteria. It is important to keep in mind that moderate needs participants

who later become high or highest needs enrollees may reflect a natural trajectory of aging or may simply be individuals who have entered the moderate needs group because they did not qualify financially for the high/highest needs group even though they may have met the clinical criteria. Therefore, the evaluation of how community needs are met should differentiate between specific subgroups within the moderate needs group.

### *Coordination of Services*

According to case management guidelines promulgated by DAIL, case managers are responsible for coordinating HCBS and other services. For instance, case managers are required to have an updated case management plan for CFC participants; however, adherence is not consistent across providers. Although the extent of provider coordination is of interest to DAIL, provider understanding of coordination guidelines and adherence may not be consistent across providers.

- Providers have questions about the extent to which they are expected to coordinate with Medicaid long-term care services that support individuals in living in the community such as durable medical equipment, prescription drugs and medical transportation as well as other medical services
- Questions also arise about the appropriate role of the case manager and/or other providers in assisting participants with activities that relate to the broader Vermont values such as participation in the community, but that are not directly related to the individual's long-term care needs. Such activities may relate to participation in religious activities, arrangements for vacations, and supports for work or volunteer activities.
- Finally, the extent to which case conferences occur is unknown. Furthermore, there are questions about the extent to which provider caseloads to allow them sufficient time to hold case conferences.

For these reasons, rather than evaluating the effectiveness of care coordination, exploratory research should be undertaken. Thus, we explore whether coordination among HCBS providers, including case managers, is occurring, the degree to which such coordination is important, and CFC facilitators or barriers to coordination.

### *Nursing Home Acuity*

We also evaluate whether there are changes in nursing home residents' acuity, based on the premise that if community services are effectively supporting participants, participants will enter a nursing home later and consequently, at a higher acuity level. Since HCBS and nursing facility care aim to serve participants with cognitive and functional limitations (although admissions into nursing homes may be triggered by specific medical conditions), there is an expectation that effective HCBS will reduce nursing home admissions or number of residents, over time. In fact, Vermont nursing home acuity as measured by residents' cognitive performance and degree of ADL dependence has already

begun to be monitored. The CFC evaluation could thus build upon the previously collected ADL dependence and cognitive performance data and continue this monitoring in future years.

The evaluation questions below and their indicators reflect these broad measures of effectiveness. While we expect that indicators of effectiveness of HCBS may also include avoidance of preventable hospitalizations, we believe that such indicators more appropriately belong in the long-term outcome.

**Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?**

**Key Indicators**

**A. Process Indicators**

Several data elements together form a picture of the movement of clients between the program's levels of need and the extent to which the program is able to respond to the changing levels of need of participants. In isolation each item is simply a descriptive element; in combination they help to document the extent to which CFC responds to individuals' different (and changing) needs and circumstances.

1. Percentage of participants moving into the high or highest needs group from a lower CFC level of need (SAMS)
2. Average length of stay by setting (SAMS)
3. Percentage of moderate needs group participants who, at admission, met clinical criteria for the high level of need (based on proxy eligibility criteria) (Review of moderate needs group's shortened ILAs in SAMS/OMNIA)
4. Average duration of time from moderate needs group enrollment to highest or high needs group enrollment for moderate needs enrollees who met high needs proxy eligibility criteria and those who did not (SAMS)
5. Number of individuals on waiting lists for high needs (SAMS)
6. Number of moderate needs participants on waiting lists for adult day and homemaker services

**B. Outcome Indicators:**

1. Increase in percentage of CFC participants in the highest, high, and moderate levels of need living in the community (SAMS)
2. Decrease in percentage of CFC participants residing in nursing homes out of the total CFC participants in the highest and high levels of need (SAMS)
3. Decrease in number of Medicaid nursing home
4. For participants in the highest, high, and moderate levels living in the community, an increase in percentage of participants responding "good" or better on survey item whether their "service meets [their] needs" (Macro survey)

## **Analytic Approach**

We will analyze process indicators 1-5 by county, age and gender to understand the composition of the enrollment groups and whether there are regional patterns of enrollment that are related to waiting lists.

We will analyze outcome indicators 1 and 2 by county and age. Doing this will help CFC understand whether community-dwellers proportionately represent both elders and younger adults and whether long-term care users are living in the community in higher percentages in some counties than other counties.

We will analyze outcome indicator 3 by county, age, and gender to determine whether there are regional differences in length of stay in nursing facilities for CFC participants. We also recognize that CFC's ability to meet long-term care needs in the community and its impact on length of stay in nursing facilities may be affected by other factors that we cannot control or account for, such as Medicaid reimbursement of medical providers, availability of accessible, affordable housing, labor market trends, and Medicare policies.

We will analyze outcome indicator 4 (participants' perceptions on the how CFC meets their needs) by age, region, gender and enrollment group (including the proxy level of need for the moderate needs group.) For the respondents to the 2008 Macro survey who have ADL/IADL functional levels available in OMNIA, we will also link the responses to this question to their ADL/IADL data to determine the extent to which participants perceptions of how CFC meets their needs is impacted by their assessed level of ADL/IADL need.

**Question 3.2: To what extent are participants' long-term care supports coordinated with each other for the purpose of providing effective care?**

**Key Indicators**

**A. Process Indicators:**

1. Percentage of participants who attended or whose family member attended a care planning meeting of total participants interviewed (CHPR interviews with participants)
2. Percentage of providers who attended a CFC care planning meeting of total interviewed providers (CHPR interviews with providers)
3. Percentage of case managers reporting they have been able to obtain information from other HCBS providers on a CFC participant in the process of care coordination of total case managers interviewed (CHPR interviews with providers)
4. Percentage of HCBS providers of total HCBS providers reporting they have been able to obtain information from other HCBS providers, including case managers, on a CFC participant when necessary (CHPR interviews with providers)

Because of the exploratory nature of this research question, only process indicators have been identified, and information will be used only for descriptive purposes. Data will be collected in only one year of the study, not measured at different points in time.

**Analytic Approach**

We will explore with participants and providers the extent to which coordination among providers is necessary, the extent to which it occurs, and mechanisms that facilitate or hinder such coordination. We will also explore the degree to which coordination with medical providers is occurring and whether this affects the quality of delivery of CFC services. We will separate coordination of services for moderate needs group from coordination for highest and high levels of need, because the financing of "moderate needs" participants is different from that of the high and highest level participants. We will make note of whether specific types of HCBS providers (e.g., home health agencies, area agencies on aging) differ in how they coordinate CFC HCBS (for whom and with which providers).

**Question 3.3: To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the demonstration period?**

**Key Indicators**

**A. Process Indicators:**

1. Major changes in the Vermont NF industry, any major federal regulatory changes with regards to Medicaid certified NF's, and CFC policies with respect to nursing homes (CHPR/UVM Interviews and review of relevant documents on trends on Vermont nursing homes).

**B. Outcome Indicators:**

1. Increase in average ADL dependency and cognitive performance scales for nursing home residents at admissions and three-months post admission (MDS)
2. Reduction in the percentage of CFC residents in nursing homes receiving assistance with only fewer than 2 ADL needs (MDS)
3. Reduction in percentage of CFC residents in nursing homes who have only behavioral symptoms less than daily (e.g., wandering, verbally or physically aggressive/abusive) (MDS)
4. Reduction in percentage of CFC nursing home residents who have both fewer than 2 ADL needs *and* behavioral symptoms less than daily (as outlined in the high needs clinical eligibility) (MDS)

**Analytic Approach**

Physical function will be measured by the summary score of activity of daily living (ADL) dependence. Cognitive function will be presented by the Cognitive Performance Scale developed by Morris et al. using MDS data elements. We will also examine the distribution of the type of ADL dependence over the study period and compare with statewide data presented in the CMS annual NF Compendium. We recognize that the acuity level, as measured by physical and cognitive functional limitations of nursing facility residents served by CFC, may also be affected by other factors, such as the state population changes and long-term care industry supply changes (both nursing homes and HCBS) that cannot be controlled in our study. We will review these indicators in light of major policy or procedural changes in the course of the CFC demonstration. We recognize that analysis of the MDS data is contingent on developing a data use agreement with DAIL and CMS.

## Outcome 4: Experience with Care

***Participants have positive experiences with the type, scope and amount of CFC services.***

### Significance

Participant experience with care (which includes their satisfaction in many areas of care) has historically been a priority outcome for Vermont LTC programs and continues to be the case with the Choices for Care waiver. In addition, “participant outcomes and satisfaction” with services is one of the domains of the CMS Quality Framework. Furthermore, given the personal nature of many HCBS, participant experiences with care are particularly salient for CFC evaluation.

While general “satisfaction” is often overstated and should be interpreted with caution, asking more specific questions related to aspects of participant experience with care can help improve our understanding of participant experiences with care. Data on participant experience is collected on numerous levels-by DAIL and by individual agencies, in relation to the various long-term care programs administered by DAIL. Therefore, to evaluate this outcome, a number of indicators were brought together to reflect the different dimensions of experiences with CFC services and not simply general satisfaction. Hence, individual indicators in this desired outcome overlap with some indicators from other desired outcomes).

**Question 4.1: To what extent do CFC participants report having positive experiences with the with types, amount and scope of CFC services?**

### Key Indicators

#### A. Process Indicator

1. Factors that affect participants’ experiences with care (CHPR interviews with state agency staff and providers)

#### B. Outcome Indicators:

1. Decrease in percentage of complaints regarding adequacy of service scope, amount, and type. (Complaints data from the Ombudsman )
2. Increase in percentage of participants rating the survey question “*services were timely*” as “good” or better (Macro Survey)
3. Increase in percentage of participants reporting that the “*quality of [their CFC] services*” are “good” or better. (Macro survey)
4. Interviewed participants and family members reporting their experiences with care improves (CHPR/UVM interviews)

October 2008 | Final Version

5. Increase in percentage of participants rating “good” or above on “*courtesy of those who help [them]*” (Macro survey)
6. Increase in percentage of participants reporting that they are getting services in the places they prefer (QMU interviews)
7. Increase in percentage of CFC participants who report “good” or better on the survey question “*services meet [their] needs*” (Macro survey)

## Analytic Approach

Interviews with state agency staff, providers, Ombudsman, and family members will be used to gather information about how individuals experience their care, whether they have concerns that result in complaints, reasons for complaints, and whether there are barriers to individuals raising concerns or seeking changes to improve their care experience. Analyzing the data over the course of the waiver allows us to identify any changes in patterns of data over time.

Trend data from reports produced by the LTC Ombudsman project will also provide process evaluation data on experience of care. Some limitations to this approach may be that complaints data may not include concerns that are unreported or are resolved before being formally registered. Similarly, we recognize that the QMU interviews may be subject to sampling bias. To partly address these limitations, we will triangulate our data analysis, drawing from the various sources (listed in the other indicators above) to get as full picture as possible about themes and patterns of complaints by the type, scope, and amount of services provided to CFC participants.

Questions pertaining to service quality and timeliness of services from the Macro consumer survey will be analyzed to examine the percentage of change in these items over the duration of the evaluation of the CFC waiver. While there is concern that self-reported satisfaction or experience data can be limited because older persons generally overstate satisfaction with services these data can be useful to triangulate with other data sources as described above in order to take into account potential biases in individual data sources.

## Outcome 5: Quality of Life

***Participants' reported that their quality of life improves.***

### Significance

Vermont is striving not only to provide high quality personal care services to meet CFC participants' services needs but also to improve other areas that affect a participant's quality of life (beyond personal care needs). For individuals using long-term care supports, quality of life is a crucial indicator. Furthermore, some research suggests that caregiver quality of life, caregiver burden, and participants' quality of life may be interconnected (Khan, Pallant, and Brand, 2007; Jones, Charlesworth, and Hendra, 2000).

The outcomes regarding participant quality of life from the CMS Quality Framework were adopted by DAIL's Quality Management Unit (QMU) and have been used in QMU's review process for home health agency providers, Area Agencies on Aging (AAAs), and adult day providers participating in the Choices for Care program. Also based on the CMS Quality Framework, a quality management plan for the state was developed to establish quality standards for assessing service providers.

**Question 5.1: To what extent did CFC participants' reported quality of life improve over the demonstration period?**

### Key Indicators

#### A. Process Indicators:

1. The process indicator for this outcome is a recommendation for consideration regarding caregiver burden (see below).

#### B. Outcome Indicators:

1. Increase in percentage of participants who report that their quality of life is good or better (Macro survey)
2. Increase in percentage of participants who report affirmatively on question of whether they are satisfied with the way they spend their free time (Macro survey)
3. Increase in percentage of participants who report affirmatively on question of whether they can get where I need or want to go (Macro survey)
4. Increase in percentage of participants who report that they can get around inside their homes much as they need to (Macro survey)

5. Increase in percentage of participants who report that they are satisfied with the amount of contact they have with their family and friends (Macro survey)
6. Increase in percentage of participants who report that they are satisfied with their social lives and connection to the community (Macro survey)

## **Analytic Approach**

Analysis of the individual quality of life items on the Macro survey could be conducted to see how well these items hold together as a single domain measuring 'quality of life'. If the items are internally consistent, as measured using standard analytic techniques to assess the items' co-variance, then a summary or composite score could be computed for each participant's responses to the individual Quality of Life items. These summary scores could be then compared across years of study or by subgroup (in lieu of or in addition to comparisons of responses to individual items). If the correlations are high between individual items, it is standard practice to reduce the number of variables in an analysis and use these composite scores to measure a single domain.

In addition, subject to the ability to link the Macro survey with demographic data from SAMS and assessment data from the ILA that may be entered into SAMS, quantitative analyses could be conducted to determine whether there is a relationship between quality of life and participant characteristics including age, gender, region, and functional/cognitive status.

## **Recommendations**

In-depth interviews with participants and family members could be used to gather data about whether their quality of life has changed since beginning participation in CFC, the extent to which CFC is related to the individual's quality of life, and what other changes the CFC program could make to further improve their quality of life.

In addition, we recommend that data on family and unpaid caregiver burden be collected as it often impacts on participants' quality of life. This data could be collected via interviews with paid and unpaid caregivers by CHPR/UVM in order to learn about factors that may affect caregiver burden and if the amount of CFC services a participant receives impacts on caregiver burden. Alternatively, a separate component of the Macro survey could be designed to target family/unpaid caregivers. Finally, a question currently on the ILA addresses the impact of caregiving on the family caregiver's job, finances, family responsibilities and health. Once this is entered in SAMS, there will be potential to analyze the relationship between the family caregiver's perspective (from the ILA response) and the participant's perceived quality of life (as reported to Macro.)

## Outcome 6: Impact of Waiting List

***CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing home, enhanced residential care, home care).***

### Significance

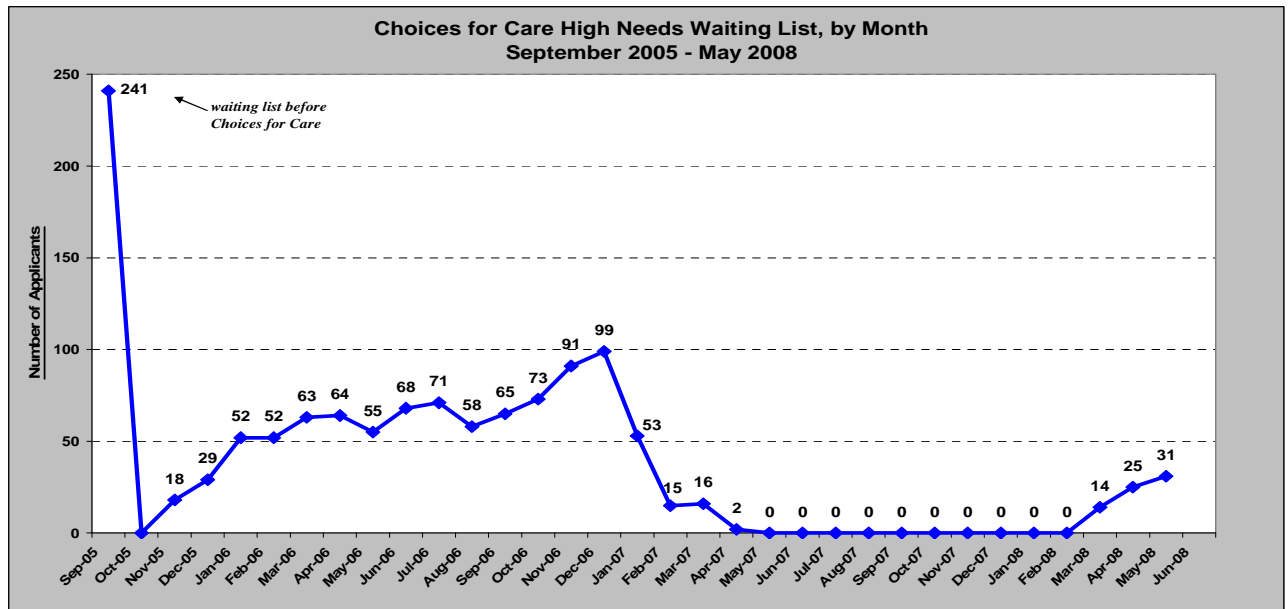
One of the unique contributions of the Vermont CFC demonstration is the decision to treat long-term care applicants equally regardless of their preferred choice of setting. Therefore, unlike most states, Vermont has created an entitlement to long-term care for individuals who meet the “highest need” criteria, whether those individuals are seeking home care, enhanced residential care or nursing facility services.

As part of this equal access, individuals in the high needs group have an entitlement to services but only if sufficient funds are available. This potential for limiting access based on available funds is also applied equally, regardless of the individual's choice of setting. While states have regularly established waiting lists for home and community-based services under Medicaid waivers, no other state has been granted authority to limit Medicaid coverage of nursing home care for individuals who meet the clinical criteria for admission albeit at a lower level than the highest need group.

Prior to Choices for Care, Vermont had a waiting list for the HCBS waiver with 241 individuals waiting as of September 2005. This list included individuals who met the criteria currently used for the highest needs group as well as individuals who now qualify for the high needs group. Consequently, even individuals who now qualify for the highest need group had to wait for HCBS. Upon the opening of the CFC program, all individuals on the existing HCBS waiver waiting list were evaluated for CFC and enrolled if they qualified.

The waiting list option for the High Needs Group was created as a financial ‘safety valve’ to allow Choices for Care to expand the entitlement to HCBS for highest need individuals while managing growth of enrollment in the high need group. Due to concerns about enrollment and expenditure patterns, in October 2005 after enrolling all existing waiting list participants in CFC, all new applicants who met the High Needs Group eligibility criteria were placed on the new CFC waiting list. The number of people on this high needs waiting list slowly increased over time. Based on availability of funds, small numbers of people from the waiting list were enrolled in Choices for Care from July 2006 through December 2006. In January 2007, Choices for Care expenditure patterns allowed all High Needs Group waiting to be enrolled, and the waiting list fell to zero by May 2007. From that time through January 31, 2008, the program was able to operate

without a waiting list for high needs applicants.<sup>7</sup> (Figure 1 depicts the number of individuals on the waiting list since the beginning of CFC.)



Due to recurring financial pressures, in February 2008 the high needs group waiting list was reinstated. Of the 25 people on the waiting list as of April 2008, 22 people were waiting for services in the HCBS setting (including one waiting for PACE) and 3 people were waiting for services in the NF setting. Since DAIL's projections at that time anticipated that the waiting list might continue for the next 18 months, some advocates had begun to refer to the list as an "applicant list" rather than a "waiting list" based on the expectation that the long waiting period might result in many applicants never accessing the program.

While this is a very difficult situation for Vermont stakeholders, it represents a key opportunity for learning about the real impact of having an equal entitlement to nursing home and HCBS. Since the intention is to treat individuals on the waiting list equally regardless of whether they are seeking HCBS or nursing facility admission, it is expected that the likelihood of enrollment will be the same for both groups, unless other factors warrant that differential enrollment rates.

Even when there is a waiting list, Choices for Care regulations allow certain individuals who meet High Needs Group eligibility criteria to be enrolled under 'special circumstances'. Criteria for special circumstances include

<sup>7</sup> Although there are also waiting lists for the moderate needs group, because the budget for moderate needs is handled through allocations to specific providers and because this program component does not include individuals who are seeking nursing home care these waiting lists are not the focus here.

- a. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse)
- b. Loss of living situation (e.g. fire, flood)
- c. The Individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued, (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
- d. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.)

Between February 1 and May 19, 2008, 49 people had been found clinically eligible under "special circumstances". This included 35 people approved for the NF setting, 10 people approved for the HCBS setting, and 4 people approved for the ERC setting. Of the 35 people approved for the NF setting, 7 people were found eligible because no 'alternative placement' was available, and 2 people were approved for short-term rehabilitation.

DAIL's intent is that the implementation of the waiting list will not create a "back door" to nursing home entry by granting special circumstances to individuals seeking nursing home admission (or individuals who are admitted to nursing homes under Medicare) at a higher rate than applicants for HCBS. However, the higher rate of admissions for nursing home applicants under the special circumstances criteria during the said timeframe raises questions about whether the program continues to retain a nursing home bias in spite of the state's efforts to eliminate it. It is also possible that the special circumstances criteria have successfully targeted those among the high needs group who are in most need of services, who are most at risk of nursing home admission, or who are most likely to choose nursing facility even when they have an HCBS option. Further research into the impact of the waiting list would help Vermont to determine whether CFC has truly met its goals.

**Question 6.1 To what extent does the implementation of a waiting list for the high needs group in Choices for Care have different impact on applicants waiting to access HCBS vs. nursing facility services?**

**Key Indicators**

To answer the various components of this question, a limited amount of new data will be needed. Through discussions with DAIL, we have proposed methods that maximize the information collected by the Long-Term Care Clinical Coordinators and in follow-up contacts by case management agencies. This information will help both DAIL and other states to understand the impact of this new approach to the management of long-term care resources.

**A. Process Indicators**

October 2008 | Final Version

Existing data captured in SAMS will be analyzed for individuals on the high needs waiting list and applicants admitted to CFC in the high needs category or based on special circumstances between 7/07-12/07 to determine whether there are different patterns of admissions based on setting, category of admission (special circumstances), or region. The following data should be collected by DAIL at a minimum:

1. Percentage of high needs applicants who are admitted under highest needs special circumstance to HCBS compared with high needs applicants admitted under highest needs special circumstances to ERCs or nursing facilities (SAMS data)
2. Percentage of high needs enrollees between 7/1/07 and 12/31/08 by setting compared with percentage of high needs enrollees between 2/1/08 and 7/31/08 by setting and by type of admission (met regular admission criteria vs. met special circumstances criteria) (SAMS data)
3. Percentage of applicants on the high needs waiting list who experience changes in status between time of being wait listed and time of enrollment into CFC (waiting list update sheets)
4. Percentage of applicants on the high needs waiting list who are receiving moderate needs services while they are waiting for an opening in the high needs component of CFC (waiting list update sheets).

## B. Outcome Indicators

Through discussion with DAIL, we expect that case management agencies will conduct monthly (or at least quarterly) follow-up contacts with waiting list applicants through which they will be able to provide some limited information about the status of individuals on the waiting list.

1. Percentage of applicants with changes in ADL or IADL function (increases and decreases will be separately tracked) following their placement on the waiting list (waiting list update sheets)
2. Data on number of hospital admissions or emergency room visits following placement on the waiting list (waiting list update sheets)
3. Data on nursing facility admissions after placement on the waiting list (waiting list update sheets)

## **Analytic Approach**

Quantitative process indicators above will be compared for individuals on the waiting list and those admitted to CFC between 7/1/07 and 12/31/07 (prior to the establishment of the current waiting list) to assess any differences in ADLs, IADLs, unmet needs, and similar elements. If or when the ILA data have been entered, a similar analysis will be performed to compare individuals who are

admitted under special circumstances before and after the establishment of the applicant list. Current SAMS data show that individuals admitted under special circumstances have a much higher likelihood of going to a nursing facility than individuals who remain on the waiting list because the latter group do not qualify for special circumstances. DAIL will be able to provide a comparison of the waiting list/special circumstances data prior to and after the reestablishment of the waiting list. These data will help document whether DAIL's procedures have retained the nursing home bias during periods of limited funding or, in practice, targeted for special circumstances those who are most likely to need or want admission to a nursing facility.

## Recommendations

In the course of considering data sources for this outcome, CHPR determined that regular telephone follow-up with individuals on the waiting list to determine any status change had not been implemented consistently by the case management agencies as DAIL had expected. We raised concerns that the lack of this information not only hampered the evaluation of the impact but, more importantly, prevented the identification of changes in individual circumstances that might qualify some individuals for admission under special circumstances. We recommended that Vermont enforce the requirement for monthly follow-up calls with applicants on the waiting list as an opportunity to reassess their needs and determine whether they may qualify for enrollment.

Much of the data for question 6.1 draw upon contact sheets that DAIL is proposing to ask case management agencies to complete. CHPR has worked with DAIL to provide specific suggestions regarding questions that could be asked in these follow-up telephone calls along with a simple format for documenting the information in order to assure that at least minimum data are collected to identify potential changes in the individual's status that might qualify them for more immediate access to CFC.

CHPR strongly believes that an understanding of the impact of a long-term care waiting list is one of the most critical contributions to national policy that Vermont can make through this waiver. CHPR had also recommended development of case studies on five individuals on the waiting list and five individuals admitted under special circumstances. Such a study would provide DAIL with a better understanding of the impact of the waiting list on long-term care access and to understand more fully how individuals qualifying for special circumstances differ from those who remain on the waiting list. While we believe this would be a valuable area to explore in understanding the impact of the CFC's waiting list policy, we recognize that the work involved in developing such a case study report is relatively expensive. Given limited resources, Vermont was hesitant to allocate resources to study the waiting list in such depth rather than to allocate such resources to serving more individuals. For this reason, we have removed those indicators from this section and focused only on information that could be

collected through routine follow-up with individuals as part of maintaining the waiting list.

## Outcome 7: Budget Neutrality

***Medicaid cost of serving CFC participants is equal to or less than the previous Medicaid and HCBS funding.***

### Significance

CMS requires that the CFC waiver be budget neutral, that is, the CFC waiver spending does not exceed what spending would have been without the waiver. Beyond meeting the requirement that CFC's actual spending does not exceed projected spending for the waiver, DAIL is also keenly interested in further shifting its Medicaid long-term care spending from institutional settings to community-based settings. Furthermore, given that a significant proportion of CFC participants are dually-eligible for Medicare and Medicaid, information on actual Medicaid health and long-term care expenditures can help to initially identify any potential cost-shifting between the two programs that adversely affect CFC budget. Lastly, if DAIL moves towards establishing a general "case rate", analysis of expenditure patterns for segments of CFC population would be crucial.

**Question 7.1: Were the average annual costs of serving CFC participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?**

### Key Indicators

#### A. Process Indicators:

1. Average annual Medicaid expenditures for each level of need and by setting (HCFA-64 reports)
2. Average annual CFC expenditures for each level of need and by setting (HCFA-64 reports)

#### B. Outcome Indicators:

1. Decrease in percentage of Medicaid expenditures for nursing facilities in comparison with Medicaid expenditures for community services for highest and high needs participants (HCFA-64 reports)
2. Ratio of annual Medicaid expenditures for CFC to DAIL projected long-term care budget (HCFA-64 reports and DAIL budget projections)

## **Analytic Approach**

Using Medicaid claims data, we will analyze expenditures by major categories of services, levels of need and by residential location, i.e. nursing home vs. community.

In addition, we recommend that Medicaid expenditures also be analyzed by clinical characteristics as reported in the Independent Living Assessment, nursing home MDS, and/or Medicare diagnostic data. Such analysis would require the merging of Medicaid claims data and assessment data or Medicare data. This would help Vermont policymakers understand participant-level factors that drive Medicaid spending.

### Section III: LONG-TERM OUTCOMES

As indicated in the logic model, long-term outcomes are those that are anticipated after the first five years of CFC.<sup>8</sup> The long-term outcomes that are discussed in this section are:

- 8. Public Awareness
- 9. Health Outcomes

In this section, we first present the intended program outcome with a brief summary of its significance, followed by the associated evaluation question or questions. As with the short-term outcomes, we present the process and outcome indicators and associated data sources, followed by the analytic approach and any outcome-specific recommendations and limitations.

#### Outcome 8: Public Awareness

***The Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long term care.***

#### Significance

The Centers for Medicare and Medicaid Services has supported state efforts to expand long-term care knowledge and insurance through the Long-Term Care Awareness Campaign known as “Own your own future.” Although Vermont has yet to participate in this partnership, DAIL recognizes that a pillar to rebalancing Vermont’s long-term care system is consumer education, which in turn drives consumer choice. As such, Vermont intends to undertake educational campaigns to improve public knowledge of long-term care options, particularly those in the community.

CFC has an explicit long-term goal of increasing the general public’s knowledge of the full range of long term care services and settings. Sources of information to individual members of the public could be through CFC options education, as well as educational efforts by other long-term care initiatives, such as the Vermont Aging and Disability Resource Center (ADRC) grant or advocacy groups. In addition, Vermont expects to initiate other relevant outreach or educational initiatives in the future.

---

<sup>8</sup> This period includes the approximately two years prior to DAIL’s evaluation contract with CHPR that began in July 2007.

Because DAIL's broader public awareness effort is not yet underway<sup>9</sup>, we suggest that the evaluation provide more specific information to help inform future educational efforts. A focus area proposed is the care transition following a hospitalization, because this transition can be a fragile juncture in quality of care and preventing an unnecessary nursing facility admission. During the transition, information on continuing care can be diluted or completely lost in communications among providers or between the provider and the patient/family. Also, hospital discharge planners may not be fully aware of community options compared to nursing homes and may have varied attitudes about these options.

In response, in 2007, DAIL added specific questions on long-term care public awareness to its survey to long-term care users and general Vermonters. Specifically, the Macro survey will collect this information on all Vermont citizens who were hospitalized within 12 months of the survey as well as CFC participants. The data gathered will allow DAIL to understand whether long-term care knowledge is lacking and to craft information and outreach approaches targeted to participants being discharged from hospitals, as necessary. Once any CFC educational initiative regarding long-term care is underway, additional evaluation questions or indicators could be developed to assess the impact of the educational activities on the broader Vermont public.

**Question 8.1: To what extent are Vermont residents who are hospitalized aware of long-term care setting options at the time of discharge?**

**Key Indicators**

**A. Process Indicators:**

1. Formation of internal workgroup or planning committee on long-term care public awareness (CHPR interviews)
2. Increase in consistency of LTCCC options education with hospital discharge planners (CHPR interviews)

As the campaign develops, other process indicators could be added related to piloting messages, advertising venues and volume of advertising, and provider training sessions on the campaign.

**B. Outcome Indicators:**

1. Increase in percentage of Vermont residents who were hospitalized within 12 months who report "*receiving information on ways to meet their daily activity needs*" at the time of hospital discharge (Macro survey)

---

<sup>9</sup> At this time, Vermont has not engaged in a broader long-term care awareness campaign to inform the general public about options. Through our monthly teleconferences with DAIL, we will learn when/if Vermont does begin such an informational effort.

## Analytic Approach

We will analyze the Macro survey item by region in order to assess the degree to which discharge planners in certain regions provide information that affects long-term care decisions. While regional analysis will not be fully effective, since individuals from across the state are admitted to the two largest hospitals, the regional analysis may still help Vermont make targeted interventions among certain hospitals.

Limitations of the analytic approach include that we will not expect to observe change in the Vermont respondents *not* served by CFC unless and until a broader informational campaign begins, and even then, research suggests that many individuals will not absorb this information if it is not immediately relevant to them. Additionally, even after the long-term care public awareness campaign is initiated, for individuals who experience a hospitalization, there may be no change in their reports about access to long-term care information unless a specific effort is targeted to hospital discharge planners.

We also recognize that transitions from hospitals to another setting do not include other potentially important points of care where information on long-term care HCBS options is critical, e.g., from nursing homes to the community or vice versa. Therefore, we recommend that nursing home residents' knowledge about HCBS options be measured as well to determine whether nursing home residents have adequate information regarding the range of long-term care options that may prove useful as they assess their permanent residence options. This information could be collected through interviews or focus groups at nursing facilities.

**Question 8.2: To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?**

**Key Indicators**

**A. Process Indicators:**

Participants' knowledge of long-term care options at the time of hospital discharge is considered an important area to explore because access to information at that time of transition could impact the setting to which the participant is discharged. Process indicators, with their corresponding data sources, include:

1. The way in which decisions were made about the kinds of services a participant would receive following a hospitalization(CHPR/UVM interviews)
2. Percentage of participants reporting affirmatively to survey question *"Before you left the hospital [if hospitalized], did someone talk to you about ways of getting the help you needed with daily activities?"*(Macro survey)
3. Percentage of CFC participants reporting affirmatively to survey question that their *"hospital dischargers took their preferences into account when planning their discharge"* (Macro survey)
4. Percentage of participants reporting affirmatively to survey question *"Were you involved in making decisions regarding the help you needed with daily activities?"* (Macro survey)

**Outcome Indicators:**

1. Increase in percentage of participants rating "good" or better on whether they *"had choice and control when planning for their services"* (Macro survey)
2. Increase in percentage of participants rating "good" or better on whether *"service fits within their schedule"* (Macro survey)
3. Increase in percentage of participants responding affirmatively to *"Do you have a say in how your services are provided?"* (QMU interviews)
4. Increase in percentage of participants responding affirmatively to whether participant's *"current setting is setting of choice"* (QMU and CHPR/UVM interviews)
5. Increase in percentage of participants responding affirmatively to whether they *"make the decisions that affect their lives"* (QMU interviews)

**Analytic Approach**

Qualitative data from the CHPR/UVM interviews will be thematically analyzed to facilitate an understanding of the mechanisms by which long-term care

October 2008 | Final Version

information is transmitted to CFC participants and how choice is promoted or hindered. Quantitative data from the Macro survey will be presented descriptively to show the number and percentage of responses to each quantifiable indicator, and analyzed to assess changes over time. Through the linkage with SAMS data (possibly including ILA data), further analyses will be conducted to understand differences to the survey question by participant characteristics; e.g., age, gender, region, enrollment group, level of impairment, and unmet needs, and CFC service delivery type.

A benefit of linking Macro survey data to participant characteristics is the ability to evaluate whether participant knowledge and perceived support in decision-making vary by different physical and mental impairments or by CFC level of need. Level of need could be a particularly important factor associated with information dissemination because the moderate needs group do not receive options education from long-term care clinical coordinators, whereas the highest and high needs group do.

## **Recommendations**

Additional process indicators that may be worth considering in the future include:

- State efforts to further strengthen the options education and counseling, both at initial enrollment and ongoing, that is delivered by LTCCC and case managers (CHPR/UVM interviews).
- Change in hospital discharger planners' and other providers' attitudes towards long-term care options and settings (This could be assessed through CHPR/UVM interviews, a survey or focus groups).

## **Outcome 9: Health Outcomes**

***CFC participants' medical are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed.***

### **Significance**

Ultimately, CFC aims to ensure that participants' long-term care needs are effectively addressed through the services they receive and that met long-term care needs will, in turn, impact health status. We recognize that CFC services themselves may not directly impact health status or hospitalization rates, but it is important to understand whether the overall medical needs of this population are being effectively addressed in order to identify opportunities (within CFC and externally) to improve the health of CFC participants. Because overall health is affected by many variables, we focus our examination of any reductions in preventable hospitalizations as an indicator of medical needs that could be impacted by early intervention and follow-up service provided by CFC.

**Question 9.1: To what extent are CFC participants' LTC needs being effectively addressed?**

### **Key indicators**

#### **A. Process Indicators:**

1. State's written standards/guidelines, development or clarifications of expectations of CFC providers in relation to participants' medical and long-term care needs, and monitoring by QMU for adherence to these expectations (CHPR interviews with DAIL staff)
2. HCBS providers' awareness of care coordination guidelines and requirements with respect to CFC participants (CHPR interviews with providers)

#### **B. Outcome Indicators:**

1. Percentage increase in participants reporting that their LTC needs are adequately addressed (Macro survey)
2. Decrease in length of long-term nursing home stay for CFC participants (Medicaid claims data)

### **Analytic Approach**

Provided Medicaid claims data and resources are available, CHPR or DAIL will analyze changes in long-term nursing home stays, i.e., lengths of stay longer than 90 days and examine changes in the long-term nursing home admission rate and length of stay by the CFC levels of needs for the CFC determination.

## **Question 9.2: To what extent are participants' medical needs addressed to reduce preventable hospitalizations?**

### **Key indicators**

#### **A. Process Indicators:**

1. Number of interviewed providers who incorporate problem identification and chronic disease management with participants (CHPR interviews with providers)
2. Number of interviewed providers who train staff on problem identification and chronic disease management (CHPR interviews with providers)

#### **B. Outcome Indicators:**

1. Percentage increase in participants whose rating of their general health is "good" or better (Macro survey)
2. Decreased rates of hospitalizations for ambulatory care-sensitive conditions (see Recommendation below)

### **Analytic Approach**

Understanding CFC's impact on participants' overall health is crucial to understanding whether any important unintended consequences occurred. The analysis of perceptions of general health is the first step in understanding such impacts. CHPR will analyze the Macro survey data by age, gender, region, enrollment group to provide a fuller picture of CFC's impact on self-perception of health. Subject to availability of the ILA data, further refinement will examine relationship between self-perception of health and the participants' functional and cognitive abilities.

### **Recommendation**

The analyses described in this section only touch the surface of the issues related to health outcomes for CFC participants. While the CFC program is not a medical program, the extent to which CFC services are coordinated with other medical services has the potential to impact health outcomes which may not be captured in the CFC data systems. Therefore, we recommend examining the hospitalization rates for specified ambulatory care sensitive conditions and tracing these patterns over the study period. This will provide CFC with a better understanding of the potential for helping participants maintain maximum health and reduce preventable hospitalizations.

Such analysis would be costly and currently exceeds the anticipated resources available for CFC evaluation. The analysis would also require access to Medicare as well as Medicaid claims data and thus would require a data use agreement with CMS. Nevertheless, CHPR recommends continuing to work with DAIL to attempt to identify

resources for such analysis. To ensure that results are available to inform policy-makers in a timely manner, explorations of potential funding and data access should be identified before the end of the initial demonstration period.

## **Section IV: GENERAL RECOMMENDATIONS**

Given the comprehensive scope of the evaluation plan, a phased approach to the analysis of process and outcome indicators and evaluation questions is planned. Hence, CHPR will work with DAIL to determine which evaluation question or indicators are analyzed in which years. As work begins on each component of the evaluation, further specifications for those indicators that are still at the conceptual level is necessary. For quantitative indicators, this will ensure that indicators are computed consistently across time and participants and in a way that meets evaluation goals.

Since data sources for most indicators are held at DAIL, with the exception of MDS and Macro survey, and qualitative data held at CHPR, the specific activities to be conducted in a particular year will be determined through a collaborative discussion between CHPR and DAIL staff regarding the most efficient approach to generating the necessary data in accordance with the specifications. Because indicator specification is closely tied with the content of the data source, CHPR will work with the DAIL units collecting evaluation data to understand and, where possible, enhance the reliability of data collection. For indicators using qualitative data sources, e.g., interviews, data collection instruments, e.g., interview guides, will be developed by CHPR in consultation with DAIL.

Baselines for each indicator will need to be established and agreed upon with DAIL. Again, baselines are indicator-specific. Since components of CFC, e.g., ERC and consumer-directed option, were in operations prior to 2005, a baseline before 2005 may be reasonable for some indicators, assuming that data sources are available for baseline data and future data. For data sources such as CHPR/UVM interviews and focus groups, the first year in which data were collected will be the baseline. Going hand in hand with establishing baseline is a discussion of the degree of change from baseline that DAIL expects to achieve. Since waivers and state environments are unique, established benchmarks for CFC are likely to be lacking. CHPR will continue to work with DAIL to determine the extent to which benchmarks should be established for certain indicators based on DAIL's expectations about the degree of change that constitutes successful achievement of goals.

As discussed previously, the full evaluation plan involves several resource-intensive data collection and analysis methods. These are analyses of changes in degree of ADL needs by CFC subgroups (question 3.1), changes in nursing home acuity (question 3.3), and analysis of Medicaid or Medicaid and Medicare expenditures by participant clinical characteristics (question 7.1). Since these analyses will be performed retrospectively, the specific year for analysis is less critical than activities that are dependent on collection of new and real-time data. At the same time, it may be important to ensure that certain steps occur to enable such analyses to be performed in the future. For instance, assessment data from the ILA can be used for multiple evaluation questions and their electronic data input will prove valuable for the evaluation as well as DAIL operations and rate-setting. Thus, we strongly recommend that DAIL

proceed with inputting the data from the ILA not just as a one-time activity (as is currently planned) but also as a long-term system improvement..

Roles for data collection and analysis will also need to be determined. If Vermont is already collecting and inputting data as part of program operations and management, this role should be continued as much as possible. However, to minimize conflict of interest and promote respondents' candidness, an external role in data collection and analysis is vital on interviews with participants and other entities. Roles for data analysis should be guided by the complexity of the data analysis. For instance, descriptive data analysis should continue to be under DAIL's purview. When or if different data sets are merged, e.g., survey results with assessment data or MDS with Medicaid claims data, CHPR can be the entity for data analysis, since the process may be burdensome for DAIL staff. Some activities, such as merging MDS data with Medicaid claims data, may also require additional resources external to DAIL as well as data use agreements with CMS. In future years, CHPR will work with DAIL to explore options to address these challenges.

Overall, the evaluation plan should be a living document. It should be reviewed and revised as appropriate or at least on an annual basis. For instance, as new policies are implemented, new process indicators may be added. If external resources become available or certain evaluation questions become more pressing, evaluation questions that were planned for a later date may be moved up in the evaluation timeline. Or some evaluation questions may become more pressing with new evaluation data emerging. For now, the planning CHPR and DAIL and Vermont stakeholders have engaged in has laid a solid foundation for evaluation work on CFC.

**APPENDIX 1**  
**Evaluation Plan List of Indicators**

**1. Information Dissemination:** CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant's expressed preferences and needs.

<b>Question 1.1: To what extent did participants receive information to make choices and express preferences regarding services and setting?</b>	
<b>A. Process Indicators</b>	
<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. The way in which decisions were made about the kinds of services a participant would receive	CHPR/UVM Interviews
2. Percentage of CFC participants rating "good" or above to the survey question that <i>"people listen to [their] needs and preferences"</i>	Macro Survey
3. Percentage of CFC participants responding affirmatively to <i>"Whether paid workers give participants enough information so participants can make decisions"</i>	QMU Interviews
4. Percentage of CFC participants responding affirmatively to <i>"When developing your service plan, did someone talk about your services AND other services that might be available?"</i>	QMU Interviews
5. Percentage of participants reporting affirmatively to survey question <i>"Before you left the hospital [if hospitalized], did someone talk to you about ways of getting the help you needed with daily activities?"</i>	Macro Survey
6. Percentage of CFC participants reporting affirmatively to survey question that their <i>"hospital dischargers took their preferences into account when planning their discharge"</i>	Macro Survey
7. Percentage of participants reporting affirmatively to survey question <i>"Were you involved in making decisions regarding the help you needed with daily activities?"</i>	Macro Survey
8. DAIL efforts to further strengthen the options education, both at initial enrollment and ongoing, that is delivered by LTCCC's and case managers	CHPR/UVM Interviews
9. Change in participants and providers' attitudes towards long-term care options and settings between 2007 and 2009.	CHPR/UVM Interviews
<b>B. Outcome Indicators</b>	
1. Percentage of CFC participants rating "good" or above to survey question that they <i>"had choice and control when"</i>	Macro Survey

<b>Question 1.1: To what extent did participants receive information to make choices and express preferences regarding services and setting?</b>	
<i>planning for their services"</i>	
2. Percentage of CFC participants rating "good" or above to survey question that <i>"service fits within their schedule"</i>	Macro Survey
3. Percentage of participants responding affirmatively to survey question <i>"Do you have a say in how your services are provided?"</i>	QMU Interviews
4. Percentage of participants responding affirmatively to whether participant's <i>"current setting is setting of choice"</i>	CHPR/UVM and QMU Interviews
5. Percentage of participants responding affirmatively to whether they <i>"make the decisions that affect their lives"</i>	QMU Interviews

**2. Access:** CFC participants have timely access to long-term care supports in the setting of their choice.

**Question 2.1: Are new CFC participants or nursing facility residents who seek discharge able to receive CFC services in a timely manner?**

***A. Process Indicators***

<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. DAIL or DCF initiatives or efforts to improve the timeliness or general user-friendliness of the financial eligibility process	(CHPR/UVM Interviews and review of documentation related to these initiatives)

***B. Outcome Indicators***

1. Percentage of CFC participants rating “good” or above to survey question “ <i>their services were timely</i> ”	Macro Survey
2. Decrease in number of stakeholders reporting specific barriers to timely services	CHPR/UVM Interviews

**Question 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their currently assessed needs?**

***A. Process Indicators***

1. Ways in which the assessment, service planning, and delivery processes facilitate or pose barriers to service access as reported by stakeholders	CHPR/UVM Interviews
2. Average cost of approved plans of care compared to average actual cost per person	SAMS/EDS

***B. Outcome Indicators***

1. Number and percentage of complaints from CFC participants regarding CFC service scope or amount	Ombudsman Complaints Data
2. Percentage of participants rating “almost always” or better to survey question that “ <i>services meet [their] needs</i> ”	Macro Survey

**3. Effectiveness:** Participants receive effective HCBS to enable participants to live longer in the community.

**Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need the community?**

**A. Process Indicators**

<u>Indicators</u>	<u>Data Sources</u>
1. Percentage of participants moving into the high or highest needs group from a lower CFC level of need	SAMS
2. Average length of stay by setting	SAMS
3. Percentage of moderate needs group participants, who at admission, met clinical criteria for the high level of need (based on proxy eligibility criteria)	Review of shortened ILAs
4. Average duration of time from moderate needs group enrollment to highest or high needs group enrollment	SAMS
5. Number of individuals on waiting lists for high needs	SAMS
6. Number of moderate needs participants on waiting lists for adult day and homemaker services	Providers' data

**B. Outcome Indicators**

1. Increase in percentage of CFC participants in the highest, high, and moderate levels of need living in the community	SAMS
2. Decrease in percentage of CFC participants residing in nursing facilities out of total CFC participants in the highest and high levels of need	SAMS
3. Decrease in number of Medicaid nursing home	SAMS
4. For participants in the highest, high, and moderate levels living in the community, an increase in percentage of participants rating "good" or better on survey item whether their "service meets [their] needs"	Macro Survey

**Question 3.2: To what extent are participants' long-term care supports coordinated with each other for the purpose of providing effective care?**

**A. Process Indicators**

1. Percentage of participants who attended or whose family member attended a care planning meeting of total participants interviewed	CHPR/UVM Interviews
2. Percentage of providers who attended a CFC care planning meeting of total interviewed providers	CHPR/UVM Interviews
3. Percentage of case managers reporting they have been able to obtain information from other HCBS providers on a CFC participant in the process of care coordination of total case managers interviewed	CHPR/UVM Interviews
4. Percentage of HCBS providers of total HCBS providers reporting they have been able to obtain information from	CHPR/UVM Interviews

other HCBS providers, including case managers, on a CFC participant when necessary	
<b>Question 3.3: To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the demonstration period?</b>	
<b>A. Process Indicators</b>	
1. Major changes in the Vermont NF industry, any major federal regulatory changes with regards to Medicaid certified NF's, and CFC policies with respect to nursing homes	CHPR/UVM Interviews and Review of Relevant Documents
<b>B. Outcome Indicators</b>	
1. Increase in average ADL dependency and cognitive performance scales for nursing home residents at admissions and three months post admissions	Minimum Data Set (MDS) data for select years
2. Decrease in the percentage of CFC residents in nursing homes only receiving assistance with fewer than 2 ADL needs	MDS data for select years
3. Decrease in percentage of CFC residents in nursing homes who have only behavioral symptoms that are less than daily (e.g., wandering, verbally or physically aggressive/abusive)	MDS data for select years
4. Decrease in percentage of CFC nursing home residents who have both fewer than 2 ADL needs <i>and</i> behavioral symptoms less than daily (outlined in high needs group clinical eligibility)	MDS data for select years

**4. Experience with Care:** Participants have positive experiences with the types, scope, and amount of CFC services.

<b>Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?</b>	
<b>A. Process Indicators</b>	
<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. Factors that affect participants' experiences with care	CHPR/UVM Interviews with participants, state agency staff, and providers
<b>B. Outcome Indicators</b>	
1. Decrease in percentage and number of complaints regarding adequacy of service, scope, amount and service type	Complaints data from Ombudsman
2. Increase in percentage of participants rating "good" or above on the survey question " <i>services were timely</i> "	Macro Survey
3. Increase in percentage of participants reporting that the " <i>quality of [their CFC] services</i> " are "good" or better	Macro Survey
4. Participants and family members reporting their experiences with care improve	CHPR/UVM Interviews
5. Increase in percentage of participants rating "good" or above on " <i>courtesy of those who help [them]</i> "	Macro Survey
6. Increase in percentage of participants reporting that they are " <i>getting services in the places they prefer</i> "	QMU Interviews
7. Increase in percentage of CFC participants who report "good" or better on the survey question " <i>services meet [their] needs</i> "	Macro Survey

**5. Quality of Life:** Participants' reported that their quality of life improves.

Question 5.1: To what extent did CFC participants' reported quality of life improve over the demonstration period?	
<u>Indicators</u>	<u>Data Sources</u>
<b>B. Outcome Indicators</b>	
1. Increase in percentage of participants who rate their " <i>quality of life</i> " as "good" or better	Macro Survey
2. Increase in percentage of participants who report affirmatively to survey question that they are " <i>satisfied with how [they] spend [their] free time</i> "	Macro Survey
3. Increase in percentage of participants who report affirmatively that they " <i>can get where [they] need or want to go</i> "	
4. Increase in percent of participants who report affirmatively to survey question that they can " <i>get around inside [their] home as much as [they] need to</i> "	Macro Survey
5. Increase in percentage of participants who report affirmatively that they are " <i>satisfied with the amount of contact they have with their family and friends</i> "	Macro Survey
6. Increase in percentage of participants who report affirmatively to being " <i>satisfied with [their] social lives and connection to the community</i> "	Macro Survey

**6. Waiting List:** CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing home, enhanced residential care, home care).

**Evaluation Question 6.1: To what extent does the implementation of a waiting list for the high needs group in Choices for Care have different impact on applicants waiting to access HCBS vs. nursing facility services?**

***A. Process Indicators***

<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. Percentage of applicants on the high needs waiting list who waiting for HCBS, compared with applicants waiting for ERCs, and nursing facilities, by month	SAMS
2. Percentage of high needs applicants who are admitted under highest needs special circumstance to HCBS compared with high needs applicants admitted under highest needs special circumstances to ERCs or nursing facilities	SAMS
3. Percentage of high needs enrollees between 7/1/07 and 12/31/08 by setting compared with percentage of high needs enrollees between 2/1/08 and 7/31/08 by setting and by type of admission (met regular admission criteria vs. met special circumstances criteria	SAMS
4. Percentage of applicants on the high needs waiting list who experience changes in status between time of being wait listed and time of enrollment into CFC	Waiting list update sheets
5. Percentage of applicants on the high needs waiting list who are receiving moderate needs services while they were waiting for CFC high/highest enrollment	SAMS and Providers' data

***B. Outcome Indicators***

1. Percentage of applicants on waiting lists who experience changes in ADL or IADL function between time of waiting list and time of enrollment	Data collected through waiting list update sheets
2. Data on number of hospital admissions or emergency room visits following placement on the waiting list	Data collected through waiting list update sheets
3. Data on nursing facility admissions after placement on the waiting list	Data collected through waiting list update sheets

**7. Budget Neutrality** Medicaid cost of serving CFC participants is equal to or less than Medicaid and HCBS funding.

**Question 7.1: Were the average annual costs of serving CFC participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?**

***A. Process Indicators***

<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. Average annual Medicaid expenditures for each level of need and by setting	HCFA-64
2. Average annual CFC expenditures for each level of need and by setting	HCFA-64

***B. Outcomes Indicators***

1. Ratio of annual Medicaid expenditures to DAIL projected long-term care budget	HCFA-64 and DAIL budget projections
2. Decrease in percentage of Medicaid expenditures for nursing facilities in comparison with Medicaid community services for highest and high needs participants	HCFA-64

**8. Public Awareness:** Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long-term care.

**Question 8.1: To what extent are Vermont residents who are hospitalized aware of long-term care setting options at the time of discharge?**

**A. Process Indicators**

<u>Indicators</u>	<u>Data Sources</u>
1. Formation of internal workgroup or planning committee on long-term care public awareness	CHPR Interviews and review of relevant documents
2. Increase in consistency of LTCCC options education with hospital discharge planners	CHPR interviews

**B. Outcome Indicators**

1. Increase in percentage of Vermont residents who were hospitalized within 12 months who report “ <i>receiving information on ways to meet their daily activity needs</i> ” at the time of hospital discharge	Macro survey
--	--------------

**Question 8.2: To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?**

**A. Process Indicators**

1. The way in which decisions were made about the kinds of services a participant would receive following a hospitalization	CHPR/UVM interviews
2. Percentage of participants reporting affirmatively to survey question “ <i>Before you left the hospital [if hospitalized], did someone talk to you about ways of getting the help you needed with daily activities?</i> ”	Macro Survey
3. Percentage of CFC participants reporting affirmatively to survey question that their “ <i>hospital dischargers took their preferences into account when planning their discharge</i> ”	Macro Survey
4. Percentage of participants reporting affirmatively to survey question “ <i>Were you involved in making decisions regarding the help you needed with daily activities?</i> ”	Macro Survey

**B. Outcome Indicators**

1. Increase in percentage of CFC participants rating “good” or above on survey question that they “ <i>had choice and control when planning for their services</i> ”	Macro survey
2. Participants’ rating “good” or above on whether “ <i>service fits within their schedule</i> ”	Macro survey
3. Percentage of participants responding affirmatively to “ <i>Do you have a say in how your services are provided?</i> ”	QMU interviews

4. Percentage of participants responding affirmatively to whether participant's " <i>current setting is setting of choice</i> "	QMU and CHPR/UVM interviews
5. Percentage of participants responding affirmatively to whether they " <i>make the decisions that affect their lives</i> "	QMU interviews

**9. Health Outcomes:** CFC participants' medical needs are addressed to reduce preventable hospitalizations and long-term care needs are effectively addressed.

<b>Question 9.1: To what extent are CFC participants' LTC needs being effectively addressed?</b>	
<b>A. Process Indicators</b>	
<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. State's written standards/guidelines, development or clarifications of expectations of CFC providers in relation to participants' medical and long-term care needs, and monitoring by QMU for adherence to these expectations	CHPR Interviews with DAIL staff
2. HCBS providers' awareness of care coordination guidelines and requirements with respect to CFC participants	CHPR Interviews with providers
<b>B. Outcomes Indicators</b>	
1. Percentage increase in participants reporting that their LTC needs are adequately addressed	Macro survey
2. Decrease in length of long-term nursing home stay for CFC participants	Medicaid claims data

<b>Question 9.2: To what extent are CFC participants' medical needs addressed to reduce preventable hospitalizations?</b>	
<b>A. Process Indicators</b>	
<b><u>Indicators</u></b>	<b><u>Data Sources</u></b>
1. Number of interviewed CFC providers who implement problem identification and chronic disease management with participants	CHPR interviews with providers
2. Number of interviewed CFC providers who train staff on problem identification and chronic disease management	CHPR Interviews with providers
<b>B. Outcomes Indicators</b>	
1. Percentage increase in participants whose rating of their general health is "good" or better	Macro survey
2. Decreased rates of hospitalizations for ambulatory care-sensitive conditions	Medicare claims data



## REFERENCES

- Constitution of the World Health Organization. In: World Health Organization. Handbook of basic documents. 5<sup>th</sup> ed. Geneva: Palais des Nations, 1952: 3-20.
- Davies, S., Laker, S., & Ellis, L. Promoting autonomy and independence for older people with nursing practice: a literature review. Journal of Advanced Nursing, 1997 (26). 408-417.
- Foster, L., Brown, R., Phillips, B., & Carlos, B.L. Easing the burden of care giving: The impact of consumer direction on primary informal caregivers in Arkansas. Gerontologist, 2005, 45(4). 474-485.
- Jones, A.L., Charlesworth, J.F., & Hendra, T.J. Patient mood and carer strain during stroke rehabilitation in the community following early hospital discharge. Disability and Rehabilitation, 2000, 22(11), 490-494.
- Kane, R., Kane R., Kitchener M., Priester R., & Harrington C., State Long-term care Systems: Reorganizing for Rebalancing. Topics in rebalancing long-term care systems, Topic paper No.2 December 2006.
- Khan, F., Pallant, J. & Brand C. Caregiver strain and factors associated with caregiver self-efficacy and quality of life in a community cohort with multiple sclerosis. Disability and Rehabilitation, 2007, 29(16), 1241-1250.
- McCullough, L.B., Wilson, N.L. Teasdale, T.A., Kolpakchi, A.L. & Shelly, J.R. Mapping personal, familial and professional values in long-term care decisions. Gerontologist, 1993, 22(2), 324-332.
- Shugarman L.R., Buttar A., Fries B.E., Moore T., & Blaum C.S. Caregiver attitudes and hospitalization risk in Michigan residents receiving home-and community-based care. Journal of the American Geriatric Society, 2002, 50(6).1079-1085.
- Vermont Department of Disabilities, Aging, and Independent Living. *Long-term care system sustainability study*. Waterbury, VT, 2007.
- Vermont Department of Disabilities, Aging, and Independent Living (2005). Annual Report.
- Ware, J.E., SF-36 ® Health Survey Update, downloaded 6/24/08, <http://www.sf-36.org/tools/SF36.shtml>.
- Wasserman, J. Shaping the Future of Long-term care and Independent Living. Vermont Department of Disabilities, Aging and Independent Living. Agency of Human Services May 2006
- Whitlatch, C.J.; Feinburg L.F. & Tucke S.S. Measuring the Values and Preferences for Everyday Care of Persons With Cognitive Impairment and Their Family Caregivers. Gerontologist. June 2005, 45 (3) 370.

Zarit, S.H., & Reever, K.E. Bach-Peterson, J. Relatives of the impaired elderly: correlates of feelings of burden. Gerontologist, 1980, 20, 649-55.

For more information, please  
contact Emma Quach at  
(508) 856-8112.



333 South Street, Shrewsbury, MA 01545  
Tel. (508) 856-7857 Fax. (508) 856-8543  
[www.umassmed.edu/healthpolicy](http://www.umassmed.edu/healthpolicy) [healthpolicy@umassmed.edu](mailto:healthpolicy@umassmed.edu)